DOCUMENT RESUME

ED 467 100 CG 031 679

AUTHOR	Cross, Terry L.; Earle, Kathleen; Solie, Holly Echo-Hawk; Manness, Kathryn
TITLE	Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities. Systems of Care: Promising Practices in Children's Mental Health, 2000 Series.
INSTITUTION	National Indian Child Welfare Association, Portland, OR.; American Institutes for Research, Washington, DC. Center for Effective Collaboration and Practice.
SPONS AGENCY	Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.; Special Education Programs (ED/OSERS), Washington, DC.
REPORT NO	Vol-I
PUB DATE	2000-00-00
NOTE	103p.; For the 1998 series, see ED 429 421-423.
CONTRACT	6-URI-SM51807-04;H237T60005
AVAILABLE FROM	For full text: http://cecp.air.org/promisingpractices/ .
PUB TYPE	Reports - Research (143)
EDRS PRICE	EDRS Price MF01/PC05 Plus Postage.
DESCRIPTORS	*American Indian Culture; *Child Health; Children; *Community Programs; Cultural Influences; Family Life; Mental Health; *Mental Health Programs; Models; Program Descriptions

ABSTRACT

Reports show that mental health services for Indian children are inadequate, despite the fact that Indian children are known to have more serious mental health problems than all other ethnic groups in the United States. This monograph examines five American Indian children's mental health projects funded by the Center for Mental Health Services (CMHS). These projects have developed extraordinarily creative and effective systems of care largely based in their own cultures and on the strengths of their families. The goal of this work is to examine promising practices that implement traditional American Indian helping and healing methods that are rooted in their culture. This monograph presents the strengths and challenges of community-based service designs that draw on culture as a primary resource. The pertinent literature is reviewed here, and it suggests that the American Indian sites described here are not alone in their pursuit of culturally-based mental health methods. Two appendixes present parent and provider questions. (Contains 56 references.) (GCP)

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Comprehensive Community Mental Health Services for Children and Their Families Program

Systems of Care
Promising Practices in Children's Mental Health
2000 Series

VOLUME I

CULTURAL STRENGTHS AND CHALLENGES IN IMPLEMENTING A SYSTEM OF CARE MODEL IN AMERICAN INDIAN COMMUNITIES

National Indian Child Welfare Association

Authors:

Terry L. Cross, Seneca, MSW, National Indian Child Welfare Association

Kathleen Earle, Ph.D., National Indian Child Welfare Association

Holly Echo-Hawk Solie, Pawnee/Otoe, M.S., National Indian Child Welfare Association

Kathryn Manness, Huron, LCSW, National Indian Child Welfare Association

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Child, Adolescent, and Family Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

CG031679

U.S. Department of Health and Human Services
Donna Shalala
Secretary

Substance Abuse and Mental Health Services Administration
Nelba Chavez
Administrator

Center for Mental Health Services
Bernard S. Arons, *Director*

Division of Knowledge Development and Systems Change
Michael English, *Director*

Child, Adolescent, and Family Branch
Gary De Carolis, *Chief*

Suggested citation:
Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

The writing of all Volumes in the 2000 *Promising Practices* series was funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. This Volume was written by the National Indian Child Health Welfare Association, through a subcontract with the Center for Mental Health Services-sponsored National Resource Network for Child and Family Mental Health Services (grant number 6 URI SM51807-04). Production of the document was coordinated by the Center for Effective Collaboration and Practice at the American Institutes for Research, funded under a cooperative agreement with the Office of Special Education Programs, Office of Special Education and Rehabilitative Services, United States Department of Education, with additional support from the Child, Adolescent, and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Administration, United States Department of Health and Human Services (grant number H237T60005). The content of this publication does not necessarily reflect the views or policies of the funding agencies and should not be regarded as such.

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Foreword

It is with great pleasure that we present the second collection of monographs of the *Promising Practices* Initiative of the Comprehensive Community Mental Health Services for Children and Their Families Program. The 2000 Series connotes a time of new beginnings for this six-year-old federal grant program, which assists communities in building fully inclusive organized systems of care for children who are experiencing a serious emotional disturbance and their families. It also represents a year of validation and pride for those who have been involved with this movement for years. As more and more evidence on the effectiveness of the system of care approach amasses we have been able to gain increased support to expand the number of grant communities and the investigation of promising practices within those communities. In his millennium report on mental health, Surgeon General David Satcher stated, "Across the Nation, certain mental health services are in consistently short supply. These include the following: wraparound services for children with serious emotional problems; and multisystemic treatment. Both treatment strategies should actively involve the participation of the multiple health, social service, educational, and other community resources that play a role in ensuring the health and well-being of children and their families." Our grant communities employ these effective approaches in combination with other community-based strategies to help these children and their families thrive. As those of us fortunate enough to participate in this initiative grow and learn, we maintain a commitment to share our knowledge and resources with all communities.

Until recently, throughout this nation, and especially in Native American communities, most children living with a serious emotional disturbance have not received clinically, socially or culturally appropriate care. These young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead these children live lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers hundreds and even thousands of miles away from their home. For many of these young people, families and communities, the absence of certain types of information has fueled the continued existence of inadequate and unresponsive service delivery systems. These service delivery networks often feel they have no alternative but to separate these children from their families and place them in costly long-term out-of-home placement. The *Promising Practices* Initiative is one small step to ensure that all Americans can have the latest available information about how best to help serve and support children who live with serious mental health problems at home and in their community.

The first generation of five-year grants has come to an end, and more than 40 new grant communities have joined the movement. These new communities will certainly benefit from the national knowledge base on how best to support and service the mental health needs of children who present major challenges, especially the contributions made by the grant communities themselves. We are proud that the information contained within these monographs by and large has been garnered within the grant communities of the Comprehensive Community Mental Health Services for Children and Their Families Program. The information was gathered by site visits, focus groups, data collected by the national program evaluation involving all grantees, and by numerous interviews of professionals and parents. We have tried to "mine" the most relevant and helpful information to inform and enlighten the reader.

The 2000 *Promising Practices* series includes the following volumes:

- *Volume I—Cultural strengths and challenges in implementing a system of care model in American Indian communities* examines the promising practices of five American Indian children's mental health projects that integrate traditional American Indian helping and healing methods with the systems of care model.
- *Volume II—Using evaluation data to manage, improve, market, and sustain children's services* explores promising practices in the use of evaluation data, and shares a wealth of ideas and experiences from these sites about using local data in ways that can impact the delivery, management, and sustainability of community-based services for children and families.
- *Volume III—For the long haul: Maintaining systems of care beyond the federal investment,* through example, examines the fundamental strategies grantee sites should consider in order to maintain long-term financial stability, with an emphasis on non-federal funding sources.

As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

The communities that have been fortunate enough to participate in our federally funded initiative have been able to incubate solutions and promising practices that work! This series represents a gift of collective knowledge and lessons learned from our grant communities to those struggling to develop effective systems of care throughout the nation.

So the 2000 *Promising Practice* Series is now yours to read share, discuss, debate, analyze and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being more able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community.
COMMUNITIES CAN!

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration

Bernard Arons, M.D.
Director
Center for Mental Health Services

Acknowledgments

This *Promising Practices* 2000 series is the culmination of the efforts of many individuals and organizations that committed endless hours participating in the many interviews, meetings, phone calls, and drafting of the documents that are represented here. Special appreciation goes to all of the people involved in the grants of the Comprehensive Community Mental Health Services for Children and Their Families program for going beyond the call of duty to make this effort successful. This activity was not in the grant announcement when they applied! Also a big thank you to all of the writing teams that have had to meet deadline after deadline in order to put this together in a timely fashion. The staff of the Child, Adolescent, and Family Branch deserve a big thank you for their support of the grantees in keeping this effort moving forward under the crunch of so many other activities that seem to make days blend into months. Thanks to David Osher, Allison Gruner, and their staff at the Center for Effective Collaboration and Practice for overseeing the production of this second *Promising Practices* series, specifically: Eric Spears, Pamela Warner, and Diedra White for word processing support; Anna Arnold for carefully editing all the manuscripts during the final production phases; Sarah Leffler and Lauren Stevenson for assisting in editing and proofreading; and Cecily Darden for coordinating the production. Finally, a special thank you goes to Dorothy Webman, who had the dubious pleasure of trying to coordinate this huge effort from the onset. Dorothy was able to put a smile on a difficult challenge and rise to the occasion. Many people have commented that her commitment to the task helped them keep moving forward to a successful completion.

AUTHORS' ACKNOWLEDGMENTS

It is with deep gratitude that we acknowledge the Child, Adolescent and Family Branch/Center for Mental Health Services (CMHS), not just for the opportunity to write this monograph on promising practices, but also for funding the five American Indian services grantees and the nine Circles of Care planning grantees. In particular we applaud Gary DeCarolis for his holistic vision of mental health practice and for his persistence and insistence in accomplishing a breakthrough shift in structuring the delivery of services.

We also thank Gary DeCarolis and Jill Erickson from CMHS for their commitment to Indian children and families. To Jill we say, "thank you" for your courage in accepting this task, which is often a lonely one for a single Indian in a complex bureaucracy. We also acknowledge the contribution of Al Hiat of the Indian Health Service for his role in helping make the projects a reality.

We acknowledge and thank our panel of seven peer reviewers, three of whom are parents of children struggling with severe mental health problems: Cyndi Nation Cruikshank, Koyukon Athabascan; Julie Acheson, Turtle Mountain Band of Chippewa; Dixie Jordan, Cherokee/Mescalero Apache; Phil Quin, Potawatomi, and his wife, Nancy; Jon Perez, Apache; and Muriel Sharlow, Fond du Lac Band of Ojibway.

We convey special appreciation and thanks to the directors and staff at K'e, Kmihqitahasultipon, Sacred Child Project, Mno Bmaadzid Endaad and With Eagle's Wings. The team thanks you not only for your time and cooperation in coordinating and participating in the interviews for this monograph, but also for your generosity of spirit. To all your staff and your community mentors and spiritual leaders, we extend our deepest appreciation for your presence in this world.

Finally, I want to salute my writing team, Kathleen Earle, Kathryn Manness, and Holly Echo-Hawk Solie. For donating her time to write the Literature Review, we extend special thanks to Kathleen Earle, and her Cayuga ancestors, for her ability to bridge both worlds with mental clarity and a heart firmly rooted in tradition.

It is with profound respect that we thank the children and parents who participated in the interviews for this monograph. As you represent the needs of our children and families, you evoke awe by your courage and resiliency and love. With humbleness, we thank you.

May it continue to be so.

Executive Summary

INTRODUCTION

Reports show that mental health services for Indian children are inadequate, despite the fact that Indian children are known to have more serious mental health problems than all other ethnic groups in the United States.[1] This monograph examines five American Indian children's mental health projects funded by the Center for Mental Health Services (CMHS). These projects hold the promise of changing that picture. They have developed extraordinarily creative and effective systems of care largely based in their own cultures and on the strengths of their families. The contributions of these projects are important because they teach us ways of overcoming the severe mental health problems faced by our communities, and provide models for replication.

The goal of this work is to examine promising practices that implement traditional American Indian helping and healing methods that are rooted in their culture. The CMHS's emphasis on cultural competence has opened the door to the demonstration and acceptance of these cultural resources as important and viable community-based approaches. As a result, American Indian grant sites are merging the systems of care model with their own local cultures and using traditional helping and healing practices that are embedded in thousands of years of Indian culture and knowledge.

This monograph presents the strengths and challenges of community-based service designs that draw on culture as a primary resource. However, cultural competence, as it applies to American Indian communities, is more complex than it first appears. The complexity stems from the enormous diversity between tribes, as well as within our communities. Despite the diversity, American Indian authors and communities have documented in recent years that traditional Indian wellness teachings and healing practices form an important component of physical and mental health care for Indian people.[2,3] The pertinent literature is reviewed here, and it suggests that the American Indian sites described here are not alone in their pursuit of culturally based mental health methods.

METHODOLOGY

As a theoretical framework, the authors use the relational model (often associated with the medicine wheel), which is based in the traditional American Indian worldview. The relational model describes mental health as a balance among context, mind, body, and spirit. This conceptual framework organizes the investigation of how grantees are using cultural interventions in their programs. Data from four of the five sites were obtained from focus groups and key informant interviews. Data from one site were gathered from written materials. The focus groups consisted of groups of parents, children, service providers, community members, and staff from collaborating programs, in various combinations. Key informants, including medicine people, elders, and other important community members, also were interviewed. Questions were designed to elicit information relating to the four quadrants of the medicine wheel, in the areas of context, mind, body, and spirit.

THE PROJECTS

The *K'e Project* provides culturally relevant, comprehensive, community-based behavioral/mental health and related services to children of the Navajo Nation, the largest American Indian reservation in the United States. K'e means to have reverence for all things in the universe and to maintain balance and harmony by acknowledging and respecting clan and kinship.

Kmihqitahasultipon ("We Remember") is a culturally based system of care for children and their families located in Indian Township, Maine. It serves members of the Passamaquoddy Tribe and draws heavily upon the community for mentors and respite care providers.

Sacred Child Project is a strengths-based, community empowerment project that is rooted within the wraparound philosophy and coordinated by the United Tribes Technical College in North Dakota. It serves the Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa and Trenton Indian Service Area.

With Eagle's Wings is a culturally appropriate program delivering wraparound services to children, youths and their families. Located on the Wind River reservation in Wyoming, it serves the Northern Arapaho Nation.

Mno Bmaadzid Endaad is a project of The Sault Ste. Marie Tribe of Chippewa Indians, in partnership with the Bay Mills Tribe of Chippewa Indians, located in the Upper Peninsula of Michigan. *Mno Bmaadzid Endaad* means "Be in Good Health at His House."

The projects, though different in stage of development, design,[4] and populations, are strikingly similar in their strategies to use culture as a resource for helping.

FINDINGS

In reviewing the responses of each site, we identified several recurring themes. The themes revealed 18 identifiable promising practices that address the integration of culture as a resource for helping children and their families. They are listed below, organized by the relational model.

Context

- Use of extended family and extended family concept (context)
- Use of cultural restoration, via mentors, groups and crafts (context, body)
- Use of methods that build connection to community, culture, group, clan and extended family (context)
- Use of elders or intergenerational approaches (context)
- Use of helping values from traditional teaching such as 24-hour care and self-care (context)
- Use of approaches that strengthen or heal the community (context)
- Incorporation of a value of respect for in-group diversity and exercising that value in services (context)

Mind

- Use of specific cultural approaches (mind, spirit, body)
- Use of cultural adaptations to mainstream system of care practices such as wraparound, respite, crisis intervention and collaboration (mind, context)
- Use of methods to promote healing of Indian identity and development of positive cultural self-esteem (mind)
- Use of methods that build up the sense of dignity and strength (mind)
- Use of methods that prepare children to live in two cultures and cope with racism and prejudice (mind, context)
- Use of the native language (mind)
- Use of all of the above, along with conventional services such as counseling, therapy and health care (mind)
- Use of conventional and cultural methods to recognize and treat historic cultural, intergenerational and personal trauma (mind, body, context, spirit)

Body

- Maintenance of an alcohol-and drug-free event policy, and dealing with substance abuse (mind, body)
- Use of specific cultural approaches such as sweat lodges, feasts, etc. (body, mind, spirit)

Spirit

- Use of traditional teachings that describe wellness, balance, and harmony or that provide a mental framework for wellness and use these as objectives for the families (spirit, mind)

- Use of methods that invoke the positive effects of spiritual belief or tap into spiritual strengths or support (spirit)
- Use of specific cultural approaches such as talking circles and ceremonies (spirit, mind, body)

This monograph is the story of communities reaching into the richness of their cultural teachings and finding new expressions for use in modern services and practices. For example, kinship networks and clan systems are being used as resources to provide respite care. Service providers and families are learning how traditional wellness concepts can facilitate a strengths-based approach to family harmony. Tools such as storytelling, ritual and ceremony, rites of passage and kinship support are being applied in a modern system of care.

QUESTIONS AND NEXT STEPS

An investigation such as this always raises new questions. Staffing issues, supervision, training, burnout and boundaries must be addressed in the cultural context of American Indian communities. Management issues such as leadership, organizational structure and integrity, and collaboration need to be examined. Funding strategies must be considered. And, of great importance, the interface between these practices and Medicaid reimbursement and managed care must be considered by policy makers and project directors if sustainability is to be achieved.

These promising practices need to gain legitimacy in mainstream America and be seen as viable and credible programs rather than mere experiments or expendable add-ons. There are strong indications that these community-based, culturally rooted programs, with 24-hour wraparound service availability, result in substantial cost savings by preventing more costly, out-of-home services. To that end, the services must be evaluated effectively, understanding of course that culturally appropriate evaluation tools and methodologies are prerequisites to effective evaluation.

Notes:

1 Swinomish Tribal Mental Health Project. (1991). *A gathering of wisdoms, tribal mental health: A cultural perspective.* La Conner, Washington: The Swinomish Tribal Community.

2 *Ibid.*

3 Earle, K.A. (1996, Fall). Working with the Haudenosaunee: What social workers should know. *The New Social Worker.*

Chapter I–Introduction

The purpose of this monograph is to examine promising practices in current use by grant sites that can be adapted by other tribes to increase their capacity to provide basic mental health services to their children and families. The contributions of these projects are important because they teach us ways of overcoming the severe mental health problems faced by our communities and provide models for replication.

BACKGROUND

The term *promising practices* is used in this monograph to describe the most promising strategies in use for helping children with serious emotional problems; that is, strategies that assist these children and their families as they try to cope with and overcome their problems. As you journey through these pages, you will learn about some of these practices for children in Indian country that are working with measurable success. We have chosen to examine promising practices that implement traditional American Indian helping and healing methods, which are rooted in this culture.

Recently, there has been a shift in thinking about the models to help children with serious mental health problems. Until recently, mental health services were provided in isolation from other services. The shift to a system of care emphasizes partnerships where multiple agencies work together with children and families. The promising practices described here exemplify this shift in thinking and show how culture and community are primary resources for addressing the mental health needs of children within a system of care. Promising practices also emphasize involving the parents of our children with the people from all the agencies that work with children. Everyone working together is a *system of care*. Parental involvement means that parents are included in the problem solving; it means that parents joining with professionals work to help their children.

For those of you reading this who are American Indian, you may be thinking, 'So what's new about this? We knew this all the time." You are most certainly right. The systems of care strategies fit very well within Indian cultures. In a later chapter we describe how traditional American Indian culture *has been* a system of care, complete within a wraparound worldview. The promising practices described here are not new practices; they are old ways in a new application; that is, the circles of care have been expanded to include partners external to the tribe.

In 1994 the Center for Mental Health Services (CMHS) funded the first of five American Indian children's mental health projects. These projects have developed extraordinarily creative and effective systems of care largely based in their own communities and on the strengths of their families.

To describe these promising practices we, the authors, conducted a review of the literature to summarize the current thinking in the field regarding the use of culturally-defined approaches in addressing the mental health needs of American Indian people. We spoke directly with program staff and families to identify the practices that were seen as culturally-based and beneficial. Finally, we analyzed the findings, reported them, and discussed the implications of those findings.

Today's Reality

Severe life stresses place Indian children at high risk for mental health problems. On a national level, Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, child neglect and suicide. Most authorities agree that there exist substantial unmet needs for mental health services in tribal communities.[1] The 1990 Census revealed that there are almost 2 million American Indian people in the United States. Of this number, 39% are under 20 years of age. Research estimates that there are approximately 93,000 Indian children with serious emotional disturbances in the United States.[2] However, reports show that mental health services for Indian children are inadequate, despite the fact that Indian children have more serious mental health problems than all other ethnic groups in the United States.[3]

Despite the existence of these tragic conditions, Indian people have historically received very limited mental health services. Theoretically available to all, these resources, in practice, have not been accessible to Indians. The geographical isolation of many reservation communities, the lack of transportation, and the inability of many Indian families to pay for services all limit access to mainstream services. This limited access is exacerbated by the deep mistrust American Indians have toward non-Indian providers and of Western models of services.

Nationwide, tribal governments have experienced great difficulty in acquiring mental health funding to provide the services that could improve the overall well-being of their children and families. Consequently, tribal governments have great difficulty trying to plan for long-term solutions necessary to promote self-sufficiency in tribal communities. This results in Indian children being the most underserved and at-risk population for serious emotional problems.[4]

In addition, significant confusion exists at the state, local and tribal levels about who is responsible for serving Indian children. Federal, tribal, state and local governments all bear some degree of responsibility for the mental health of all children. Their perception that "the other agency is responsible" has resulted in virtually no coordination of services, let alone the development of a formalized system.

American Indian authors and communities have documented in recent years how traditional Indian wellness teachings and healing practices form an important component of physical and mental health care for Indian people.[5,6] These traditional helping and healing practices are embedded in thousands of years of Indian culture and knowledge. Many Indian people have deep faith in these methods of help, and report receiving great benefit from the services that engage such traditional practices. In spite of this, these traditional practices have rarely received either professional respect or financial support from the mental health system. At best, historically, they have been regarded as supplementing Western models. At worst, they have been rejected as pathological, mythical or superstitious.

Despite these impoverished resources and confusion over jurisdiction, Indian communities continue to demonstrate the resiliency and creativity that have characterized their ongoing struggle for survival. In 1994, CMHS funded the first of five current Indian children's mental health projects. Recently CMHS funded nine planning grants, called *Circles of Care*. These are three-year planning grants to American Indian communities to develop systems of care for their children with serious emotional problems. These systems will include partnerships with Indian and non-Indian agencies. Parents and families are the grantees' primary partners in developing the model systems.

Only recently have the public, government and the medical field begun to recognize the importance of mental wellness in the balance of society as a whole and specifically to value traditional cultural practices as valuable resources. The emphasis of the CMHS on cultural competence has opened the door to the demonstration and acceptance of these cultural resources as important and viable manifestations of community-based approaches.

Cultural Competence

Cultural competence has been defined as "the state of being capable of functioning effectively in the context of cultural diversity."[7] *Organizational cultural competence* is defined as "a congruent set of policies, structures, practices, and attitudes which come together in an organization and enable the organization to effectively work in cross-cultural situations."[8] This model of cultural competence is comprised of five elements. The *first* is valuing diversity. Culture is a resource for helping, rather than a problem to be solved, and provides a rich source of new knowledge and practice skills. The *second* is awareness of one's own cultural values. We must know how culture shapes our concepts of mental health and the form of our services to be able to effectively describe them. The *third* element is understanding the dynamics of difference. For example, ethnocentric misinterpretation and misjudgment have historically resulted in culturally biased interventions with Indian people, sometimes with negative results. The *fourth* element is the development and use of cultural knowledge; that is, knowledge of tribal culture, its in-group diversity and its unique mental health issues and practices. Finally, the *fifth* element is adaptation to the culture. Services are designed to fit the beliefs and practices of the local community, to tap into the natural helping systems and to use cultural strengths as a resource.

The first four elements mean little if we do not work with people in a way that fits their culture and makes the most of existing resources. When culture is integrated into services, every aspect of practice is affected. For example, how families are interviewed, who is defined as family, and how the strengths of a family are assessed are all conducted from community-based models. Later in this monograph, we will describe how the five American Indian grant sites are merging the systems of care model with their own local cultures.

Cultural competence, as it applies to American Indian communities, is more complex than it first appears. The complexity stems from the enormous diversity between tribes, as well as the diversity of our communities, as shown by differences between people who live in a traditional life style and those who live according to mainstream norms. There also are great differences between people who embrace native spiritual practices and those who are Christian or who do not adhere to any spiritual belief system. Families have their own distinct cultures, which have emerged out of this complex history. Service providers must be aware of the extent of this diversity and not assume any one family will have the same cultural beliefs as other families.

Despite this diversity, there are some guiding principles to help program developers and service providers when they are working with native people. There are values shared by most, if not all, Indian nations, tribes and communities. Even in the communities struggling with great pain and in enormous states of distress, these traditional values persist. These values of community before self, hospitality and reciprocity, and spirituality as a 24-hour experience continue to bring Indian individuals into the community circle, which has and continues to enable us to both survive and flourish.

TRADITIONAL METHODS AS PROMISING PRACTICES

Traditional cultural helping and healing methods are a cornerstone of *promising practices* of the American Indian CMHS grantees. Under this initiative, the whole child is considered within the context of his/her family and community; and, consistent with a traditional American Indian view of the world, a child with a serious emotional disturbance is viewed as sacred. The grantees recognize the heritage of American Indian peoples and the wisdom and strength of traditional teachings about health and healing. This monograph is the story of communities reaching into the richness of their cultural teachings and finding new expressions for use in modern services and practices. For example, kinship networks and clan systems are being used as resources to provide respite care. Service providers and families are learning how traditional wellness concepts can facilitate a strengths-based approach to family harmony. Tools such as storytelling, the use of ritual and ceremony, rites of passage and kinship support are being applied to a modern system of care.

Our goal is to create a foundation of information to help identify promising, culturally-appropriate, strengths-based, mental health practices. We intend to demonstrate the strengths and challenges of community-based service designs that draw on culture as a primary resource.

To accomplish this goal, we use a model based in the traditional American Indian worldview. This relational model describes mental health as a balance among mind, body, spirit and context. Using this simple conceptual framework to organize the investigation of how grantees are using cultural interventions in their programs, the authors interviewed families, youth, elders, staff, community leaders and spiritual leaders to find out how the programs address each of the four quadrants of the relational model. The results are enlightening and evocative.

The following chapters: (1) describe the model used to organize our investigation; (2) report on the resulting methodology; (3) examine the literature in this old (to Indian practice), but emerging (in mainstream practice) area of cultural mental health practice; (4) briefly describe each of the five projects; (5) relate the findings from the data-gathering process; and, (6) discuss the implications of the findings.

You should be aware that the model presented here is just one way to organize thinking in this area. Many American Indian people may disagree with our method of presentation. We apologize in advance for any omissions or statements that offend or trouble our Indian elders, teachers, colleagues, friends or family. Our purpose is to inform others about the great potential resources that American Indian cultures offer our children and families.

To the casual reader this will be an interesting read, because it tells the story of a people's rediscovery of their own capacity to heal their families and communities. To the Indian family and/or professional, it is a story of hope and validation. We hope you are enriched by it.

Notes:

[1] The Swinomish Tribal Community. (1991).

[2] Deserly, K.J. & Cross, T.L. (1996). *American Indian children's mental health services: An assessment of tribal access to children's mental health funding.* Portland, OR: National Indian Child Welfare Association.

[3] *Ibid.*

[4] Cross, T.L. & Rylander, L. (1986). *Gathering and sharing: An exploratory study of service delivery to emotionally handicapped Indian children.* Portland, OR: Regional Research Institute, Portland State University and Northwest Indian Child Welfare Institute.

[5] The Swinomish Tribal Community. (1991)

[6] Earle, K.A. (1996, Fall).

[7] Cross, T.L. *et. al.* (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, D.C.: Georgetown University: Child Development Center.

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Chapter II–Making Sense of Culturally Specific Promising Practices: An American Indian Model

INTRODUCTION

One of our greatest challenges is to communicate to a multicultural audience information that is specific to a culture. The American Indian grantees have taken the values of systems of care literally and made their services both community-based and culturally competent. This means that each grantee (or site) has drawn on the strengths of its community and culture to shape the services they provide. In some cases the intervention practices are so completely integrated with the culture that it is difficult to describe to outsiders what is culture and what is the project. We believe that this is a healthy expression of a community-based, culturally competent service design. However, it means that any discussion of culturally based interventions must be grounded in a discussion of the culture itself, its underlying worldview, and its concepts of health and healing. Our approach is grounded in a theoretical model and is discussed below to help put the promising practices described later into their proper cultural context.

It is important to know that there is great diversity among Indian people tribally, regionally, historically and politically. Great diversity among individual tribes results from differences in geographic locations, levels of assimilation, spiritual beliefs and intermarriage. We honor that diversity. For the sake of communication, theory and practice development, it is useful to identify general models.

Further, our view of what constitutes a promising practice is shaped by our view that our culture is our strength and that regaining lost or diminished cultural ways is essential to the mental health of our children, families and communities. We also start this process with the belief that desirable outcomes can only be defined locally within the context of the culture. Promising practices must be viewed in the context of the outcomes that they are designed to produce in the local community and local culture. For American Indian children, being a good relative may be as important an outcome as academic achievement; interdependence may be as important as self-sufficiency; and knowing the rituals of one's tribe may be as important as getting along with others.

Finally, we have not attempted to judge the value of an intervention based on culture, but rather have asked providers, parents and youth to report what is working for them. The definitions of success are as diverse as the communities. This is the nature of a community- based model. For Indian people these children's mental health initiative projects represent the first opportunity in 200 years for American Indian communities to address the needs of children and families with serious emotional disturbances in a self-determined, community-based, culturally competent manner.

RELATIONAL WORLDVIEW AS AN ORGANIZING MODEL

The relational worldview, sometimes called the cyclical worldview, finds its roots in tribal cultures. It is intuitive, non-time oriented and fluid. Balance and harmony in relationships is the driving principle of this thought system, along with the interplay of spiritual forces. The relational worldview sees life in terms of harmonious relationships; health or wellness is achieved by maintaining balance among the many interrelating factors in one's circle of life. Every event relates to all other events regardless of time, space or physical existence. Health exists only when all elements are in balance or harmony.

In the relational worldview, helpers and healers are taught to understand problems through the balances and imbalances in the person's relational world. We are taught to see and accept complex (sometimes illogical) interrelationships that can be influenced by entering the world of the client and manipulating the balance contextually, cognitively, emotionally, physically and/or spiritually.

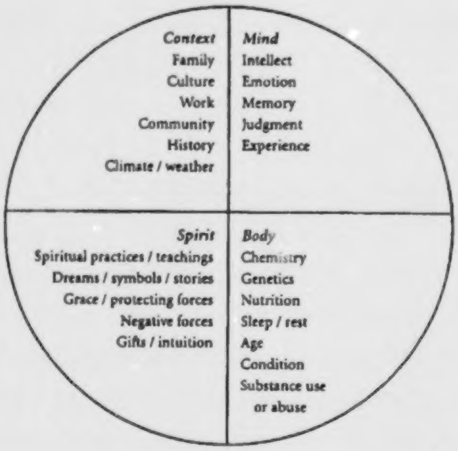
Interventions need not be logically targeted to a particular symptom or cause, but should be focused on bringing the person back into balance. Nothing in a person's existence can change without all other things being changed as well. Hence, an effective helper is one who gains understanding of the complex interdependent nature of life and learns how to use physical, psychological, contextual and spiritual forces to promote harmony.

A RELATIONAL MODEL

We use the relational worldview model as our conceptual framework. We use it to organize the literature review and to design the data gathering and reporting. In isolation, you might see traditional cultural practices as add-ons or auxiliary services. Our use of the relational worldview is intended to show the richness of these practices as core components of a culturally competent system of care.

- As described in the literature review to follow, the four quadrants represent four major forces or sets of factors that together must come into balance. They are context, mind, body and spirit.
- The *context* includes culture, community, family, peers, work, school and social history.
- The *mind* includes our cognitive processes such as thoughts, memories, knowledge and emotional processes such as feelings, defenses and self-esteem.

- The *body* includes all physical aspects, such as genetic inheritance, gender and condition, as well as sleep, nutrition and substance use.
- The *spirit* area includes both positive and negative learned teachings and practices, as well as positive and negative metaphysical or innate forces.



The four quadrants are in constant flux and change. We are not the same person at four p.m. that we were at seven a.m. Our level of sleep is different; our nutrition is different; and very likely, our context is different. Our behavior, feelings, and thoughts will also change. The system is constantly balancing and rebalancing itself as we change thoughts, feelings, and our physical and spiritual states. Individuals, families and even communities experience this natural process. If we are able to stay in balance, we are said to be healthy; but sometimes the balance is temporarily lost. We have the capacity as humans to keep our own balance for the most part, and our different cultures provide many mechanisms to assist in this process. Spiritual teachings, social skills and norms, dietary rules and family roles are among the myriad of ways we culturally maintain balance.

Death is an example of an event that threatens harmony. When we lose a loved one, we grieve. Physically we may cry, lose our appetite or not sleep well. Spiritually we have a learned positive response, a ritual called a funeral. Usually, such events involve the community, thus changing the context. We bring in relatives, friends and supporters. In that context we intellectualize about the dead person. We may recall and tell stories about him or her. We may intellectualize about death itself or be reminded of our cultural view of that experience. Physically we touch others, get hugs and handshakes; we eat and we shed tears.

These experiences are interdependent, playing off each other in multirelational interactions. If successful, they allow us to resolve our grief by maintaining our balance. If we cannot, then in a Western sense we are said to have unresolved grief or, in some tribal cultures, to have a ghost sickness or to be bothered by a spirit. Different worldviews often use different conceptual language to describe the same phenomenon.

Cultural Approaches to Helping Families

When helping an Indian family, programs that rely heavily on cultural models ask the following:

- "What are the holistic and complex interrelationships that have disrupted the balance in the family?"
- "What factors can come into harmony and allow a family to not only survive but to grow strong?"

Harmony, in this worldview, is regarded as the natural state of human existence. The natural tendency is for individuals and families to try to find balance and harmony and to heal from painful experiences. These natural tendencies are regarded as powerful allies in the helping processes. Like the helper, families also are responsible for learning about and seeking balance.

Because of differences among tribes, the language and specific applications of the relational worldview are different for each of the five American Indian sites that participated in writing this monograph. To understand how these sites are using cultural approaches to help families, we used the relational worldview as an organizing, theoretical model. We structured our interview questions around this theme and examined how the activities of each site promote harmony within the family. The nature of our strengths and challenges becomes evident as we examine family strengths from a relational perspective.

First Quadrant: Context

The context within which Indian families function is one filled with strength-producing, harmonizing resources. Oppression, for all its damage to us, creates an environment where survival skills are developed and sharpened. We learn to have a sixth sense about where we are welcome and where we are not. We teach our children to recognize the subtle clues that spell danger. We sit with our children at the movies or in front of the TV and interpret, cushioning the assaults of the mainstream media. We learn how to cope with the dynamics of difference and pass our strategies on to our children.

The richness of our histories and heritage provides anchors, which hold us to who we are. Our relations, relatives or kin, often form systems of care that are interdependent and rely on these systems. Healthy interdependence is the core of the extended family. It does not foster dependence and does not stifle

independence. Rather, it is a system in which everyone contributes in some way without expectation of reciprocity. I give my cousin a ride to the store; while at the store, my cousin buys some items for our grandmother. Our grandmother is home watching my brother's children, who are planning to wash my car when I return home. No one person is paying back another, and yet the support and help keep cycling throughout the family.

The community provides additional influences. From church to social organizations to politics, we all are affected by the events in the world around us. Family resilience is supported by role models, community norms, church structures and the roles of elders and natural helpers or healers. However, we also struggle with negative forces in our environments: poverty, oppression, substance abuse, unemployment, crime, trauma, or any of hundreds of other negative influences. Together these enter into the balance of who we are and how we cope.

Second Quadrant: Mind

The Indian family is supported intellectually by self-talk and by the stories we hear about how others have managed. Sitting around the kitchen table or on the front steps, we learn strategies for interacting with the world or how to use resources. In passing on the stories of our lives, we pass on skills to our children and we parent for resiliency. We instill the values of relationships, getting by and not needing, and hard work for little return. Storytelling is perhaps our greatest teaching resource for communicating identity, values and life skills. Stories let us know who our people are and what can be expected from them. They also provide subtle cues for behavioral expectations.

Emotionally, we learn a variety of ego defenses that allow us to deal with overwhelming odds. Denial, avoidance, repression, and disassociation are some useful mechanisms for surviving oppression. Functionality can only be understood within context. For example, many of our families know real pain and endure grief beyond the comprehension of many Americans; yet they give back to their community. Because of oppression, substance abuse or poverty, many have learned not to need, not to feel and not to talk about their suffering; still, they help out at the church and at school or give their sister a break from her kids. These are acts of kindness that bring life-sustaining energy that flows from auntie's approving looks, a child's laugh or a pat on the back.

Other emotions rob people of their resources—rage, depression, anxiety, grief and jealousy, among others—and are likely to contribute to a lack of harmony. Our people have experienced generations of loss from which we are only now beginning to recover. This sense of loss and the intergenerational grief that is a part of it are strong elements affecting the balance of our families.

Third Quadrant: Body

When talking about the individual, we think of this quadrant as concerning the body. In family it also means the family structure and roles. Kinship, expressed in how we relate to our relatives, how we act as a system, and how we sustain each other, will greatly influence the balance in our lives. Eating is one activity that families often do together. Our culture's particular foods, our use of foods, our use of foods to mark special occasions, and our rituals around eating together, are all contributing factors to the health of our families.

Physical health, diet, sleep habits, exercise and physical comfort all contribute to the sense of harmony we experience. If our child has a disability, we compensate in other ways. If we have little, we learn to make do and to share what little we do have with others.

Fourth Quadrant: Spiritual

Spiritual influences in the family include both positive and negative learned practices. The positive practices are those we learn from various spiritual disciplines or teachers: faith, prayer, meditation, healing ceremonies, even positive thinking. They are the things we learn to do to bring about a positive spiritual outcome or to bring positive spiritual intervention. Negatively learned practices include curses and bad medicine. Sin, behaviors that create chaos or promote confusion, are learned negative spiritual behaviors. These actions bring forth negative spiritual outcomes or negative spiritual interventions. Rituals, ceremonies, songs, sacred objects, water, "medicines"[1] and sacred sites are all relied on by Indian peoples to varying degrees and provide a strong harmonizing force.

Here, our teachings and spiritual institutions play a great role. Usually there are learned positive practices meant to counter the negative practices—those we engage in or those done by someone else. Often, what is considered positive in one person's faith is considered negative in another's; and the lines between the two become blurred by emotion. In Indian communities, the churches and/or traditional spiritual beliefs play a significant role in shaping the spiritual practices of the family.

In a relational worldview, human behavior is also influenced by spiritual forces. Luck, grace, helping spirits and angelic intervention are a few of the terms used to describe getting just the right help at just the right time. One does not have to believe in or practice any spiritual discipline to believe in or experience the phenomenon. Bad luck, bad

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spirits, ghosts, the devil and misfortune are a few of the terms used to describe things that bother people no matter what their spiritual practices. These forces are often turned back or controlled through prayer, rituals or ceremonies.

Summary

In the relational worldview all causal factors are considered together. It is the interdependence of the relationships that gives understanding of the behavior. Adapting to the constant change and interplay among various forces creates resilience. We can count on the system's natural tendency to seek harmony. We can promote resilience by contributing to the balance. Services need to be targeted not to a specific set of symptoms, but toward restoration of balance. Family support services are an example of adding to the balance.

It is not simply our extended family or church or survival skills or any other single factor that provides family harmony. It is the complex interplay among all of these factors. Getting in harmony and staying in harmony is the task.

Ways of Helping

From a relational perspective, "the problem" resides in the relationship among various factors. In this monograph we examine several approaches that work within a relational worldview framework; that is, traditional, cultural methods of helping and healing that primarily focus on the restoration of balance and harmony. The practices we describe may work in the realm of the mind with advice, counsel, and therapy or with storytelling and dream work. They may work in the body realm with fasting, sweat lodge or nutrition. They might work in the spirit realm by sharing traditional teachings or by connecting families to ceremonies or healing rituals. Always, these programs become part of the context of the person being helped and add to his balance with his presence and support. By using these practices in a holistic approach, the program becomes a system of care.

Notes:

[1] Plants used ceremonially are referred to by Indian people generally as "medicines."

Chapter III–Literature Review: Mental Health Care for Native American Youth

The mental health treatment of Indian youth is as old as the culture itself. Historically, the term *mental health* was not used, but cultural and spiritual teachings promoted health and well-being in every aspect of life—physical, mental, emotional, social and spiritual. Traditional cultural methods of maintaining mental health have persisted in Indian country despite over a century of suppression. So strong has been the persistence of these ways that over the last 20 years, they have been integrated with Western approaches.

Members of American Indian tribes or nations share history and beliefs that are not found among other groups in the United States and Canada, and these understandings need to be incorporated into any healing approach used with Native Americans. Today mental health work with American Indian people may include, among other methods, the use of indigenous healers, outpatient clinics, residential treatment centers for substance abuse, hospitals (to a lesser degree) and sweat lodges. It includes speaking and listening, and sometimes requires waiting for the right moment to intervene. Strategies may include understanding current problems within the context of the individual's family and tribal history, bolstering self-esteem through cultural activities, and involving the extended family and tribal community in the treatment plan.

CONCEPTUAL FRAMEWORK

When working with native people, the use of a conceptual framework that is culturally appropriate is necessary. One framework familiar to most American Indians can be loosely described as the original *wraparound* model.

Wraparound has been defined as a "philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes."[1] The relational worldview utilized by native people fits perfectly into the definition of wraparound; indeed, it may be called the *original* wraparound approach.

Wraparound is a relational model of care in which all aspects of care for a child are fully integrated with that child's environment. This model is in contrast to the linear models that dominate much of current mental health practice. The linear worldview perceives a cause-and-effect relationship and can be visualized as a direct line from cause (example: social history) to effect (symptoms) to treatment plan (new cause) to goals of treatment (new effect). The strength of the linear model is that it is easy to measure. Its weakness is that it fails to address the whole person.

The relational worldview, in contrast, can be visualized as a four-quadrant circle, or *medicine wheel.* The four quadrants are four major factors that must be in balance in order to achieve well-being. They are context, mind, body, and spirit. These four factors are in constant flux, and the system is constantly balancing and rebalancing itself. Wellness is achieved when the four quadrants are in harmony.[2, 3] We use the model of the medicine wheel and its four quadrants to organize the literature review.

Context

There were approximately ten million people who were called "Indians" when the first European explorers came to America. Within four hundred years (1500–1900) the population was reduced 66% to 95%.[4] Today there are approximately 560 federally recognized tribes and two million American Indian people in the United States. Most tribes still maintain the sovereign nation status given to them by the U.S. Constitution and reaffirmed by the *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 (1831) and *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515 (1832) Supreme Court decisions.[5] As members of sovereign nations existing within another country, American Indians are unique among minority groups in the United States. Many laws and court cases have modified the status of Indian sovereign nations since 1832; some American Indians have chosen to become fully integrated citizens of the United States or Canada; many have not. This history is an important consideration within the area of context, or the social sphere of being, as Indian people have developed survival skills and relationships with other cultures based partly on their recent (last 500-year) history.

Within most tribal communities, relations, relatives, and kin form systems of care that may be called "extended families" that neatly fit the definitions of wraparound, involving both kin and community. In healthy American Indian settings, children, who are given a special place in these communities, are watched over and cared for by all.[6]

Mind

Despite exposure to other ways, American Indians have been incredibly tenacious in maintaining a worldview that differs substantially from that of most other residents of North America. This worldview includes elements of acceptance, trust, and group identity that are in conflict with American cultural values based on the primacy of the individual.[7] The standard American view of mental illness embraces the cultural norms of self-reliance and an internal rather than an external locus of control. In contrast, many American Indian communities view themselves and their members as a true "mental health community" in which all members are responsible for the illness and cure of the person who is affected. There is a widespread belief that emotional illness, like physical illness, is caused by disharmony with oneself, nature, and one's community, and cure involves restoring balance.[8] Using this understanding of wellness, questions of diagnosis and treatment are secondary; and many different approaches can be used to reach the same goal of a return to harmony.

Western treatment approaches such as ecological, cognitive and behavioral, psychodynamic, family systems, constructivism, and narrative theoretical models have been successfully used with American Indians. Sensitive, culturally appropriate interventions can be applied via any one of several modalities, if therapists are trained in the communication style of the client.[9] Understanding complex and often subtle differences in interaction styles is crucial to the therapist's ability to establish a therapeutic application.

Some authors have reported difficulty in applying standard mental health diagnostic tools with native people. Difficulties are due both to the tools themselves and to differences in definitions of emotional illness between some Indian clients and non-Indian therapists, despite efforts of the American Psychiatric Association (APA) to address these issues. The "Outline for Cultural Formulation" found in Appendix I of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)[10] is one such effort. It includes suggestions for culturally sensitive diagnoses as well as several diagnoses unique to certain cultures (but without official DSM-IV codes needed for billing). Novins, *et al.* (1992), have found the "Outline" to be inadequate for diagnosing American Indian children, although the authors commend the APA for its effort. According to these authors, the "Outline" does not adequately address child-rearing patterns or the cultural identity of the caregiver, and it does not provide for shifting patterns of cultural adaptation. For example, an adolescent might have an increased attachment to being an Indian wheereas, he was unaware of his cultural identity as a child.[11]

Other authors have found DSM diagnostic tools adequate for American Indians, but have noted difficulties in the application of these tools and concepts. For example, in a recent, comparative study of native and non-native children, there were no differences in ratings of emotional disorders between the two groups using parent and self reports; but non-native teachers rated higher levels of conduct disorders among native children compared with non-native children.[12]

There also have been specific, clearly defined, emotional problems identified among several indigenous groups in the United States and Canada. The diagnosis and treatment of these difficulties are related not to the attainment of insight, the goal of much Western-style therapy, but to the restoration of balance. In the Lakota language, for example, *mental health* translates as *ta-un* ("being in a state of well-being"). As stated above, well-being is defined in most American Indian cultures as a state of harmony among mind and body, social roles, family, and community, all of which are interrelated and inseparable.

Trimble, Manson, Dinges, and Medicine (1984) provide several examples of indigenous concepts of disorder that do not have an equivalent DSM-IV definition.[13] Examples of some of the disorders discussed in this paper are *windigo, pibloktoq*, and *iich'aa*. Windigo (witiko, wiitiko, whitiko) has been described as a (rare) form of mental disorder among the Ojibwas, Cree, and other northern Algonquin people. Pibloktoq, translated as "arctic hysteria," has been observed and recorded primarily among the arctic and subarctic Eskimo population. Iich'aa, or "moth sickness," has been reported among the Navajo. In 1975, Lewis described the *wacinko* syndrome, which occurs primarily among the Oglala Sioux.[14]

An example of one of these diagnostic groups is as follows: symptoms of pibloktoq are described by Trimble, *et al.* (1984), as mild irritation followed by sudden wild excitement in which the person may tear off his clothes, break things, and act irrationally, followed by convulsions and falling into a stuporous sleep, after which he behaves normally and does not remember the experience.[15] Pibloktoq has been said to occur in both males and females, and its existence is believed to be related to the socially sanctioned outlets for both hostility and hysteria-like behavior in traditional Eskimo religion. Some Western researchers have postulated that it may be attributed to the long winter darkness and severe climate. Pibloktoq is included as one of the unique diagnoses in the DSM-IV "Outline for Cultural Formulation and Glossary of Culture-Bound." Unfortunately, this diagnosis cannot be used for billing purposes.

Body

Family and cultural norms around eating and drinking, as well as aspects of health, nutrition, and exercise, also affect the degree of harmony of a person. The use of food marking special occasions strengthens family and community bonds, while it helps individuals to feel loved and appreciated. Alcohol has been used by American Indians for hundreds of years, but was originally used under controlled circumstances associated with ritual.[16] Alcohol abuse, recognized to be higher among American Indians than among the general population, has been linked to the lack of emotional well-being, including mental illness and child abuse and neglect among Indian families and individuals. Wide variations in alcohol use have been found among American Indian tribes. Some tribes have lower rates of alcohol use than the general population.[17,18] Among adolescents, alcohol use and conduct disorders are commonly reported emotional problems.[19]

High rates of alcohol-related criminal activity, death, and accidents are associated with inappropriate lifestyle choices by some American Indian groups. These choices include peer-related binge drinking on a regular basis; and risky, vehicular-related behavior (drinking and driving and lack of seatbelt use, for example).[20] As with other emotional difficulties, alcohol abuse is interpreted by many native people as having a spiritual rather than a physical cause, thus needing a spiritual cure. Treatment may involve the use of herbs or tribal medicines, as well as medicine men or other natural healers in traditional purification or other ceremonies or rituals.

Spirit

Spiritual influences can be both positive and negative. Positive practices include prayer, meditation, and healing ceremonies. Negative forces may include curses or illness brought on by evil forces outside the individual.[21] A person's actions can bring about negative consequences. These may include, for example, treating a sacred object with disrespect. Individuals also must be careful not to upset the harmony of their environment. For example, when traditional Navajos leave their homeland, they may experience emotional dislocation, which can negatively affect their pursuits away from the reservation. This emotional trauma is believed to be based on an unconscious sense of having violated the natural order of the universe.[22]

Reports abound in the literature regarding the need to use a culturally appropriate, therapeutic approach with native people.[23] Specific American Indian intervention strategies include the use of the medicine wheel, sweat lodge and medicine cards.[24,25,26] Several studies describe the interplay of culture and healing among adolescents in American Indian communities.[27] Generic or "pan-Indian" tools, common to many Indian tribes, may be modified to meet the unique beliefs of each American Indian tribe or nation, with the understanding that they may be foreign to some and, therefore, inappropriate.

PROMISING PRACTICES THAT WORK

Various programs and concepts for the treatment of emotional difficulties among native young people appear in monographs and conference proceedings that have not been reported in professional journals. These presentations and papers provide a wealth of information regarding treatment options for Native Americans. There are many other *promising practices* that do not appear in any type of literature but are shared through conversations. Several examples of existing promising practices will be discussed in the next section.

The Medicine Way

Charles Lonewolf (Omaha) presented an overview of approaches to the healing of Indian youth at the 1988 conference "Encircling Our Forgotten" in Oklahoma. Lonewolf characterized the emotional imbalances among youth as consisting of three kinds: karmic, environmental, and dietary. He explained that karma refers to the opportunity each young person has chosen by being born in this time and place to these parents. This can be seen as a challenge or a blessing, an opportunity to learn where we are out of balance and to re-align ourselves.

He further stated that the environmental causes of emotional distress, such as alcohol and drug abuse and Fetal Alcohol Syndrome (FAS), are due to material imbalance, in which we have focused on material gains and lost our focus on the spiritual. Lonewolf suggested a refocus on the old values of community above self and cited the lessons of the medicine wheel, with the four directions symbolizing the whole, as a tool for helping people make the right choices each day. He also suggested meditation and purification rituals as means to achieve clarity and guidance, and the rhythm of the drum and flute as reminders of the harmony of the universe with the heartbeat of life.

Diet is another cause of emotional illness. Not only are foods processed and filled with chemicals, but the animals that are killed live in high-stress environments. Medications that are overused add to the imbalance, as do x-rays. Many foods, such as sugar and alcohol, are polluting our bodies. Lonewolf suggests dietary changes to improve both physical and mental health.

The Seattle Indian Health Board

Designed to serve native people from many tribes who are now living in an urban setting, this program combines traditional wisdom and treatments with Western therapeutic approaches. The program began in 1969 as an all-volunteer medical clinic open three nights a week in a donated space. Fifteen years later it was one of the most comprehensive, off-reservation, primary health programs for native people in the United States. The program stresses the involvement of tribal council and social services staff in program planning, and the use of tribal members who are recognized as "helpers" or traditional healers to treat native people within their own tribe. Programs focus on the treatment of the community as opposed to the individual. Treatment methods are flexible and non-intrusive. Paperwork is minimal. When necessary, Indian paraprofessionals and professional supervisors collaborate on diagnosis, including both a diagnosis from the Diagnostic Statistical Manual and a traditional Indian diagnosis. Staff fully support and advocate for cultural practices and customs. Tribal professional providers are encouraged to attend community and spiritual events to integrate themselves into the community. In the spirit of collaboration, staff attempt to develop close working relationships with other mental health providers. Staff provide cultural education and share clinical training in these relationships. On-going consultation promotes respect for and understanding of the unique customs and beliefs of each separate Indian community.

Communication Patterns

In a paper presented at the Uniting Our Concerns conference in Minnesota in 1991, Gonzalez raised concerns that behaviors labeled "dysfunctional" among mainstream therapists may actually reflect Indian traditional behaviors. The following are examples within some tribes:

- talking about problems is not acceptable
- open expression of emotions is not allowed
- the most appropriate way to communicate is indirectly

Gonzalez cautioned listeners that counselors who work with addictions may view many of these patterns, familiar in Indian society, as dysfunctional. American Indians, who feel that everything must exist in harmony, believe that nothing can be judged as "right" or "wrong." They believe that everything that happens to us is part of a larger scheme. This is reflected in communication patterns that denote respect and selflessness. He suggested that persons who counsel native people look for the motivating factors behind their communication patterns to determine whether they are healthy or dysfunctional. He stated that native people who were communicating poorly, even within the context of their own culture, were in a state of fear, self-defense, and insecurity. These states can be improved through counseling and by the individual participation in tribal healing rituals, such as talking circles and sweat lodges, as well as in informal, traditional gatherings.

Cultural Congruence

At the Encircling Our Forgotten conference in Oklahoma in 1990, Jennifer Clarke stated that rather than seeing traditional healing as an adjunct to standard therapy, mental health programs for American Indians and other ethnic groups should be founded on cultural values with mainstream services as the adjunct. Rather than improving the cultural sensitivity of mainstream therapists, culture-specific approaches for service delivery should be created.

With this model, mental health care is harmoniously integrated into an existing, organically functioning system. Congruence is obtained among all elements, such as language spoken, cultural beliefs, and all parts of the therapeutic encounter. Elements such as the use of traditional healers, the recognition of culture-specific symptoms, and the involvement of extended family members are examples of dimensions to be addressed. Clarke stated that the true client is the tribal community, that a positive cultural identity is necessary for good mental health, and that spiritual values and practices must be recognized and accepted.

Zha We Ni Dig

The traditional wellness circle encompasses several elements found in many native tribal beliefs. These include use of the medicine wheel and sweat lodge, and incorporation of traditional healers to help persons with emotional problems. Frances and Henrietta Sherer presented Zha We Ni Dig at the 1989 and 1990 Encircling Our Children conferences. The sacred circle opens with prayer, thus putting the gathering in the hands of the creator. Smudging with sacred herbs is part of the opening ritual.[28] Members are purified and connected through prayer and smudging, and sacred objects may be passed around as well. Each person shares what he or she wants to share for as long as he or she wants to share it, and all maintain a respectful silence. All that is said is meant for the creator, and no one is to repeat it. The sacred circle is a means to total wellness.

Project Making Medicine

Training in traditional approaches to emotional healing is provided by Project Making Medicine through the University of Oklahoma Health Sciences Center, Center on Child Abuse and Neglect. Delores Subia Bigfoot has presented the approaches used by the center at several recent conferences hosted by the National Indian Child Welfare Association (NICWA). Culturally based training is provided for mental health and substance abuse personnel who work with tribal members. Clinical care is based on a cognitive-behavioral model that is compatible with tribal beliefs. The sacred circle, medicine wheel, sweat lodge, and other frequently used native traditions are used in training the therapists and counselors. When these individuals return to their communities, they will use some of the methods to restore balance to the tribal people to whom they will provide services.

Elements that are central to Project Making Medicine are respect, the use of storytelling, and how discipline is described and used among native people. The approach is based on strengths found in the community, and these are used to restore balance to the community and the individual.

The American Indian Counseling Center—An Urban Model

The American Indian Counseling Center (AICC), a mental health program run by the Los Angeles County Department of Mental Health in California, won a national award for creative programs. What follows is a description of the program from the former program manager.[29]

"We described ourselves as a community integration program and had several features unique to a county mental health program.

"Most mental health departments/programs had socialization programs, a lighter form of day treatment. They were always age-specific and included only the identified patients. I implemented a multigenerational, community-oriented socialization program aimed to increase the socialization skills of severely emotionally disturbed adults and children. Every Thursday, well and ill clients of all ages came together. We started with a prayer and smudging and went into a talking circle, using an eagle feather. We separated the children for therapeutic play with a couple of the adults. We taught parents how to play with their children. We facilitated appropriate peer interaction through traditional crafts and a program newsletter. The newsletter was put together by the clients, including artwork, poems, stories, etc., and articles and editorials by staff.

"Lunch was provided by the program but cooked and served by the clients and staff together, as was the cleanup. A woman's group was held in the afternoon, and men continued to socialize.

"Another part of the program was bussing clients, including homeless mentally ill children and adults, to powwows, cultural activities and community events.

"We celebrated special achievements, for example, the first year anniversary of a woman who had finally been psychiatric hospital-free for one year.

"This program had some success in finding a community volunteer family, so as to avoid placing a severely mentally disturbed girl into a foster home while her mother underwent residential substance abuse treatment.

"We had watchers for a pregnant woman who had had several fetal alcohol and drug addicted children removed from her care. She was living on the streets in a refrigerator carton. Program staff worked probably ten hours per week with this woman, frequently, to help her come through the pregnancy with an undamaged baby. Today, after years of severe, chronic substance abuse and homelessness, this woman is working and caring for three of her children.

"This community integration program brought together members of different tribes and helped them create a mutual commitment to support each other through episodes of mental illness decompensation, substance abuse relapse, and other life crises."

Case Example: A Promising Practice in an Urban Setting

A referral came in from the juvenile justice department to the Indian center in Los Angeles of an 11-year-old who was ditching school, and stealing and hiding goods under the apartment building where he lived with his mother, aunt, maternal grandmother, a sister and a couple of cousins. The probation officer thought the teen had a severe anxiety disorder. The following promising practice illustrates a culturally appropriate family intervention.[30]

> *"It was a [tribe was named] family. I did all the interventions in the home as opposed to office visits ... The grandmother was the matriarch of the family—the elder—the one to whom I should address interventions. This is different from mainstream care, which assumes that you address the child and the mother.*
>
> *"I knew that to 'get down to business' was impolite, considered intrusive and aggressive and usurping the place of respect for the grandmother. I introduced myself. The grandmother, Mrs. T, introduced me to the other family members. She kept calling me Miss Menace (I introduced myself as Kathryn Manness.) We did small talk, who you knew, etc., until we identified people whom we both knew. When asked, I answered personal questions, for example, that I was married and had a son and stepchildren.*
>
> *"It was three weeks before Mrs. T brought up the problems her grandson was having, and she introduced the subject in a round-about way. 'What do you think about kids these days?'*
>
> *"I told her stories that my father had told me when I was growing up—stories that illustrated appropriate behavioral interventions when kids were misbehaving. I made up or used stories that would parallel this family's situation and provide suggestions I would say something like, 'Once my father told me this story about this family of otters.'*
>
> *"Grandmother had been raised with traditional tribal, child-rearing techniques that worked well when she was a child within a large extended family, where all adults took responsibility for teaching the children appropriate and constructive behaviors. In Los Angeles, these support systems were unavailable, and there were entirely different environmental influences at play that required different strategies.*
>
> *"On the sixth session I gave grandmother a calendar where each month's artwork had been painted by a different artist, all from her tribe. Now, that would be unacceptable in mainstream social work. Grandmother was thrilled. She started calling me Mrs. Manness from that session on.*

"On the eighth session, we really got down to business with direct discussion of what was happening. I went back three or four more sessions, a total of twelve. TT was going to school, hanging out with different kids (per grandmother's ultimatum); his grades were already improving; his anxiety had decreased.

"On my last visit there, the family invited me to join them for dinner. They served me steak; they had hamburger. They served me first. They all watched me eat in silence. They gave me sage."

SUMMARY

Traditional spiritual practices combined with the strength of community commitment pave the way for today's most promising mental health practices. Conventional practices and inadequately trained non-Indian providers are at risk to misdiagnose and consequently, implement harmful interventions. Community-based, Indian-run programs offer creative, effective promising approaches to serving American Indian children and their families. Funders must continue to support the use of these approaches to provide a healthy environment for the children of the original inhabitants of North America.

In working with American Indian children with emotional difficulties, using the methods employed by indigenous people for centuries is supported in the literature as well as in the examples of current practice cited above.

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Chapter IV–Methodology

PROCEDURES

Data from four of the five sites were obtained from focus groups and key informant interviews. The focus groups consisted of groups of parents, children, service providers, community members and staff from collaborating programs, in various combinations. Each site was asked to schedule from two to several group meetings for participants. Meetings were scheduled for a two-to-three-hour time frame and were held over a period of one to three days. In some cases visits were held at different times and sites for the same project. The *K'e Project*, due to time constraints, was unavailable for interviews.

The National Indian Child Welfare Association (NICWA) provided a luncheon and an honorarium of $35.00 cash to each parent and child who participated in the focus groups. The honorarium and a thank-you note for participation was placed in an envelope and given to each person at the end of the meeting.

A sign-in sheet for meetings included a statement regarding the purpose of the interview, an assurance of anonymity, and the participants' agreement to participate and was used as a consent form for the interviews. The focus group leaders had available to them a script to use as an introduction to the process, a schedule for the meetings, site-visit protocols, and a list of questions in the medicine wheel format.

Key informants, including medicine people, elders, and other important community members, also were interviewed when available and interested.

The number and status of persons (whether a person was a parent, staff member, etc.) interviewed in the focus groups and individually thus ranged from six separate interviews, including a camp-out with staff, parents, children and spiritual leaders at one site, to two fairly structured interviews and a debriefing at another.

NICWA staff and consultants conducted interviews at the project sites at a time convenient for the providers. The group interviews were either taped or recorded with hand-written notes. In the case of key informants, some of whom did not want to be taped, notes were taken either at the interviews or later by the NICWA representative.

The *K'e Project* was unable to meet the time constraints of the interview process; for this project, written material, largely unpublished, and the project's own written evaluation were used to provide information for the Findings section of the monograph.

Questionnaire

Questions were designed to elicit information relating to the four quadrants of the medicine wheel, in the areas of context, body, mind, and spirit. A list of questions provided to the staff people who conducted the interviews included specific questions to be asked in each of the four areas. For example, a question in the area of context for providers was: "How does your program draw upon extended family and kinship to help parents help their children?" A question in the area of mind for parents was: "How has the program helped you develop strategies that use Indian ways for addressing the needs of your child?" The questions were modified for increased clarity after use at two of the sites, with the input of the Passamaquoddy program staff. Both sets of questions, each used at two of the sites, appear in the Appendix.

Interviewers were instructed to begin with the least intrusive questions and to identify group members who were uncomfortable with the questions for potential one-to-one follow-up interviews later.

Questions were designed to start with a specific cultural focus and to allow for more broad-based responses as well. Although a list of questions was provided to NICWA staff who conducted the site visits, and in some cases to the interviewees, interviewers also relied heavily on comments that departed from the specific questions asked, but provided a more in-depth description and analysis of the projects. Interviewees were encouraged to tell their stories as they saw necessary or relevant. This anecdotal information was an invaluable measure of the projects' health and progress to date.

Data Analysis

Information from the five projects, in the form of hand-written notes, notes from the audiotapes, and in one case notes from written material, were reformatted to fit within the four quadrants of the medicine wheel. Either transcripts from the visits or the reformatted written material was then sent back to the study sites for review for accuracy and appropriateness. Quotations from each site were used to illustrate findings in each of the four quadrants of the medicine wheel.

Chapter V–Project Descriptions

The five American Indian grantees share similar philosophies as well as several similar characteristics, as you will see from the following project descriptions and findings in the subsequent chapter. The projects are all community-based and draw upon traditional culture as a launching pad for therapeutic interventions. Staff are committed to their projects and the participants in these projects to an extraordinary degree. Staff are available 24 hours a day.

All projects embrace culturally specific forms of wraparound approaches. They are all committed to partnerships, both within their communities and externally with non-Indian and other Indian entities.

K'E PROJECT

The *K'e Project* (started October, 1994) is a project of the Children and Families' Advocacy Corporation (CFAC). It provides culturally relevant, comprehensive, community-based behavioral/mental health and related services to children from birth to age 22 with serious emotional disturbance or those at risk for these difficulties.

The *K'e Project* delivers services to the Navajo Nation, the largest American Indian reservation in the United States. The Navajo Nation sits in the four corners region at the intersection of Arizona, New Mexico, Utah and Colorado. It extends into Utah and New Mexico, with its largest land base in Arizona. The Nation encompasses 26,187 square miles. The area, known for its natural beauty, is primarily a semi-arid plateau punctuated by mountains held sacred by Navajo teachings . In 1991, the population was more than 196,000 and 50% were 19 years of age and younger.

Many Navajo people maintain and highly value a subsistence lifestyle. Others have placed an emphasis on economic development and cooperation with various agencies in attaining self-determination. Although the Nation has made significant progress in developing and running its own health and human services, a great many people suffer from severe social conditions, including unemployment; poverty level incomes; and intergenerational abuse fueled by various addictions, particularly alcoholism.

Mission

The *K'e Project* is committed to becoming partners with children and families to help them nurture their bodies, minds and spirits and to have available mental health services that are appropriate and culturally sensitive in the least restrictive environment. Their philosophy is: *"We believe that every family has the strength and wisdom to walk in beauty."*

Program Description

K'e means to have reverence for all things in the universe and to maintain balance and harmony by acknowledging and respecting clan and kinship.

CFAC/*K'e Project* is a nonprofit organization that is governed by a board of directors. The board consists of ten members who serve a term of two years each. Seven of the board members are parents or consumers of the *K'e Project*. Services are delivered in Chinle, Fort Defiance, and Winslow, Arizona; and Tohatchi, Shiprock, and Crownpoint, New Mexico. The administrative office is in Tohatchi.

The *K'e Project* began services through a five-year CMHS grant in late 1994. It had become increasingly clear that non-Navajo approaches to serving children and families were not responsive to the needs of the Navajo people. Such models were seen as categorical and too frequently emphasized physical health while neglecting mental and behavioral health.

The *K'e Project* relies primarily on Navajo concepts of health and well-being in its delivery of services to children and families. These concepts place family at the center of children's mental health. Further, the provider is aligned with the family in a cultural context, which values families and their participation in their children's healing.

Using K'e teachings and practices as the central process of healing, the *K'e Project* provides an array of primarily home-based services.

Services include:

- Both in-home and outpatient counseling and therapy that is strengths-based and family centered
- Traditional/cultural counseling and healing that includes *K'e* teachings and practices in efforts to strengthen family and clan relationships as well as assistance obtaining support services for traditional healing
- Behavior management services to maintain children in the home via positive skill development
- Aftercare and follow-up counseling and support services upon completion of treatment
- Prevention and community education, including outreach, referral, collaboration, networking and community education
- Case management and advocacy for adequate and appropriate resources to support and empower individuals and families

KMIHQITAHASULTIPON "WE REMEMBER"

Kmihqitahasultipon (which began operation in October, 1997) is a culturally based system of care for children and their families. Located on the North East border of Maine and Canada, Indian Township is home to 700 tribal members of the Passamaquoddy Tribe and an additional 200 descendants and nontribal residents. The reservation encompasses 100,000 acres in Washington County, one of the ten most impoverished counties in the United States. Having withstood over 400 years of acculturation, this community is rich in its historic tradition, spiritual values and traditional beliefs. These beliefs and values have fashioned the unique One on One and Respite programs of *Kmihqitahasultipon.*

Mission

(From *Kmihqitahasultipon* Program Values Statement)

"We believe that individuals should be treated with respect, honoring the paths we all have taken through past challenges and successes."

"We believe people grow, change and react in ways to accommodate individual differences and past pain."

"We support and encourage the best in each family and individual, acknowledging that people do the best they can."

Philosophy

Kmihqitahasultipon realizes that native communities have human resources that frequently go unrecognized and untapped. These resources, when blended with mainstream clinical expertise, create strategies that are enormously effective in resolving mental health problems among native children, families and communities.

Program Description

Kmihqitahasultipon, in addition to other services, features a "Respite and One on One" program offering two important services for children and their families. The respite services are developed around the individual needs of each family. The program provides time for parents and caretakers to have a break while program caregivers provide therapeutic respite care. The amount of time allotted for respite care is based on an assessment by one of the coordinators of the program and the child's parent or caretaker. It assesses the needs of the family and encourages caretakers to take good care of themselves. A parent may need time just for herself so that she can be the best parent possible; at other times the service is used to relieve stress in crisis situations as a way to prevent child abuse.

One on One is designed to meet each child's specific needs. The needs may relate to juvenile justice prevention or recovery from trauma. A child is matched with a mentor, and the plan of intervention meets a variety of the child's needs while fostering self-esteem on the part of the provider. Supportive activities may address the body quadrant, such as swimming, biking or fishing. The focus is on building skills that will enhance the client's ability to cope, including anger management, saying no to inappropriate peer behavior, surviving crises, etc. Plans are continually reviewed and modified to foster an on-going improvement in functioning within the community. For example, after a month of one-on-one interaction with a community mentor, a new plan may be developed that includes time with other children. The goal is to increase the child's number of productive social behaviors, thereby increasing his or her success in peer relationships. These guided learning experiences with the child's mentor-friend have shown remarkable results.

Enhancing children's self-esteem is a primary goal, along with helping them to feel connected not only to their mentors but also to their extended tribal community. The program reinforces the concept that all tribal members are family and care for each other. For the mentors, who are members of the community and paid through *Kmihqitahasultipon*, this involvement contributes to the molding of their own future as caring, productive individuals and community members. "Many providers say that their child does more for them than vice versa in terms of their own sense of hope, involvement and commitment to the community. Others have stated that it has aided them in the healing of their own childhood wounds."

Recruitment of mentors is an ongoing process. To date 52 community members, aged 16 to 56, have been trained by *Kmihqitahasultipon* as mentors. All providers undergo an application process that includes: a background check through the tribal police department, drug screening that can be repeated at the request of the program, two references, and the completion of a questionnaire on why they wish to be a provider and how they see their role with children. Providers receive all-day initial training, augmented by further training in first aid, CPR and on-going support meetings.

Training covers required protocols, confidentiality, mandated reporting laws, health center and program policies, child development, communication, discipline and how that relates to teaching, appropriate and effective intervention strategies, and progress recording. Progress notes document concerns, gains and activities. Mentors and parents have a minimum of a once weekly contact with the program coordinators.

In addition to this community-based program, *Kmihqitahasultipon* provides traditional mainstream therapy services and additional in-home support. It has established an excellent relationship with Harvard University Medical School telepsychiatry. Harvard provides weekly teleconsultation, monthly in-person consultation, case consultation and training. This relationship fills a gap that almost all other Indian mental health programs experience.

Kmihqitahasultipon is a community-based program that is truly integrated into the community. The wraparound services embrace all other tribal human services, including medical health services, schools, spiritual ceremonies, and crafts mentoring from community crafts persons.

Like most, if not all, Indian and Alaskan Native programs, Kmiqitahasultipon staff follow traditional values, which sometimes differ from mainstream values. Adhering to tribal traditional expectations of community healers, staff are available to clients without regard to time restrictions. Their involvement, while professional, is also personal. This duality reaps enormous benefits for the community members who avail themselves of *Kmiqitahasultipon* services.

SACRED CHILD PROJECT

Sacred Child is a strengths-based, community empowerment project that is rooted within the wraparound philosophy of services. It is coordinated through the United Tribes Technical College in Bismarck, North Dakota. They serve five sites: Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa and Trenton Indian Service Area.

More that 25,000 American Indians reside in North Dakota, but according to 1990 U.S. Census figures, that number could be up to 25% higher. Also, the project serves reservation or service areas that extend into Montana and South Dakota.

There are important features of this project. (1) Services are delivered to the families using a team-centered wraparound model and a plan of care that focuses on 12 life domain areas. (2) Fifty-one percent of the team working with any given family is there at the request of the family. (3) Through a set of visioning sessions, partners from virtually all levels of government (state, federal, tribal, Indian Health Service, Bureau of Indian Affairs) and business have been cooperating toward a common vision for North Dakota Indian children and families.

Key challenges are working with several tribes in three states and issues of sustainability. The project has just begun its second year.

Mission

> *"To join with families to ensure that children grow positively in mind, body, spirit and emotions."*
>
> *"The mission of the* Sacred Child Project *is to implement the wraparound process and to assist the five North Dakota tribal nations, Spirit Lake Tribe, Standing Rock Sioux, Three Affiliated Tribes, Turtle Mountain Band of Chippewa, and the Trenton Indian Service Area, to develop a strategic mental health plan for Native American youth on reservations in North Dakota."*

Philosophy

> *"Every child is sacred. It is the teaching of our ancestors to embrace each child in unconditional love and caring, and enable them to become what the creator intended them to be."*

Sacred Child recognizes that native families and communities have unrecognized and untapped strengths that hold the keys to wellness. These strengths are rooted in native traditions and values. The only way to heal the wounds that have created the massive mental health problems with which Indian children and families struggle is to draw upon these strengths. This process establishes and promotes community sharing of the responsibility to heal itself. *Sacred Child* rests upon the foundation of these traditions and values. They provide their services within the wraparound model that addresses the entire array of needs of children and their families. They understand that their enrolled children and families vary in character on the continuum of traditional to assimilated. *Sacred Child Project*'s philosophy embraces the diversity within communities.

Project Description

Sacred Child staff and spiritual consultants have an unconditional love for the children and their families who participate in the project. Participants come to *Sacred Child Project* through referral, by having read promotional material, or by knowing other participants in *Sacred Child Project*. Referrals come through various tribal programs, tribal schools, indigenous healers and spiritual advisors.

After completing an enrollment application, potential participants are visited by a care coordinator and, if available, a parent coordinator. Care coordinators are more commonly known in mainstream social work terms as case managers; however, out of respect for the family, these positions were renamed to more appropriately convey what their function is, which is to assist the family by coordinating care. Families are not considered cases, nor does a staff person manage them. The care coordinator's qualifications do not hinge on whether he or she has a four-year degree. What is more important is that they understand the community dynamics and culture and that they are aware of the services and programs in the community. They also need to respect the community and be willing to train to become certified in care coordination.

The parent coordinator ensures that families are treated with respect and that the families' voices are heard. To qualify, parent coordinators must have a child who has emotional or behavioral challenges or, because of the role of the extended family in Indian culture, an extended family member with these kinds of issues. The parent coordinator must know what it is like to have to maneuver the diverse systems in the community, access the various services, and be able to identify with the frustration felt by parents. Above all, they must be there to support the parent or caregiver.

During the pre-enrollment visit to the family, the staff provides information about the *Sacred Child Project*, the wraparound process and the enrollment process. This is done to ensure that the child and family understand what the project does so they can decide whether they would still like to apply. If they are still interested, their application is then forwarded to the local Wraparound Review Intake Team (WRIT), a multidiscipline team composed of parents, care coordinators and representatives from cultural, spiritual, child welfare, mental health, law enforcement, juvenile justice, education, alcohol and substance abuse prevention, and domestic violence areas.

The intake team determines whether the child is eligible for enrollment according to the following criteria: (1) Is the child involved in two or more systems? (2) Is the child in danger of being removed from the home, school or community or is the child transitioning back into the community? (3) Does the child have emotional or behavioral issues and has he or she been diagnosed, or is he or she diagnosable, with a serious emotional disturbance?

After accepting a child into the project, the intake team assigns the child to work with a care coordinator. Care coordinators work with only ten children and their families. The assigned care coordinator notifies the family that their child has been selected for enrollment and sets up a time and location to complete the intake process. The location is always convenient to the family. The care and parent coordinators visit with the family, including the child and other siblings in the household. Consistent with tradition, a social process ensues. If the care coordinator is unfamiliar with the family involved or vice versa, the conversation usually begins with who their relatives are and identifying common interests. These conversations are the first step in building a relationship and a gradual and gentle way of moving toward a list of questions that help identify family culture, potential child- and family support team members, and strengths of the child and family. A psychosocial history is not taken.

The next step in the wraparound process is to set up a meeting of the child and family support team. At this meeting, the parents or primary caregivers and the child, if age appropriate, meet other members of the child and family support team (CFST). This team is comprised of people the family has identified as being part of their natural support system and the service providers from the systems with which the child is involved. The family determines who sits on the support team. For some families, only natural support people will be involved until the family becomes comfortable with the wraparound process and is willing to include the professional service providers. There have been families whose natural support system has broken down, so the care coordinator also will work to re-establish or find natural supports for the family within the community. The natural support members include extended family, indigenous healers, elders, cultural advisors, clean and sober friends and other community members the family is interested in inviting to the table.

The purpose of the support team meeting is to develop a plan of care appropriate for the family's strengths and culture. Depending upon the age of the child, the child shares in the decision making. At the first support team meeting, the care coordinator briefly explains the wraparound process and sets the ground rules, always emphasizing a strengths-based approach. Often the families or the service providers slip back into a deficit-based approach, which is common in current practice.

While identifying the child's needs, the *Sacred Child* care coordinator continually focuses the child and family on their accomplishments, strengths, interests and vision for the future. The parent coordinator's role is to ensure that the parents' voices are heard in the process and are not overwhelmed by the professionals who may be sitting at the table. Throughout the process they will be there to support the parents and may at times be the ones to provide the touch-love approach to parents, when the parents' behavior may be jeopardizing the child's well-being and healing.

Each child is carefully observed with regard to his or her own unique and special strengths. Although areas are targeted for intervention because of problems that are frequently of a serious nature, sometimes of life-threatening proportion, these problem areas are seen through the filter of strengths that the individual, family and allies can bring to bear on them.

Cards with topics from 12 domains are placed before the child and parents.[1] The child and parents select the domains they want to work on. If there are other family member issues that are affecting the healing process of the child, a plan of care is also developed for that family member. The role of the support team members is to assist the child and family in developing strategies and resources to meet the needs of the child, based on the child's and family's unique strengths. Because the issues are frequently serious and sometimes life-threatening, the crisis domain is always included in the three life-domain areas to be worked on. This is to ensure that the plan of care is pro-active instead of reactive to the child's emotional or behavioral issues.

When the family first enters the *Sacred Child* wraparound process, the support team meetings are held as frequently as once a week. With time and diminishing need, the meetings are held with decreasing frequency until disenrollment. Disenrollment only occurs if:

1. The family moves out of the service area.
2. The child is no longer interested in working the process.
3. The child and family feel sufficiently empowered that they no longer need the project.

All of the *Sacred Child* reservation sites offer wraparound care coordination to children and family enrolled in the project. Each site also has flexible wraparound funds to meet the needs of the family. The wraparound flexible funds are approved through the plan of care developed by the support team. The plan of care documents what interventions are used, the resources used to implement the intervention, the costs associated with the intervention, and the outcomes of the plan of care. The plan of care changes as different life domains are selected and the needs of the child change.

Each reservation has tailored the *Sacred Child Project* to fit the needs of their community. While each reservation site works with the Indian Health Service (IHS) mental health staff and the existing child and family serving programs, each site has developed special initiatives. Spirit Lake and Turtle Mountain have contracted with and share services of a clinical psychologist who works in conjunction with IHS mental health staff. Fort Berthold and Standing Rock have strongly integrated American Indian cultural healing practices into their wraparound process. Prior to the *Sacred Child Project*, Fort Berthold had the services of an IHS psychologist who came once a month to the reservation. Standing Rock, Spirit Lake and Turtle Mountain each had one psychologist who worked with all of the reservation's adult and child populations.

The addition of the *Sacred Child* clinical services and spiritual/cultural help has increased the therapeutic avenues available to families and provided a spiritual foundation for healing for some families. *Sacred Child* staff and parents acknowledge the need for access to other professional staff to fill the gap in services. However, as part of the *Sacred Child Project* goals, the project will work with each reservation in developing a comprehensive children's mental health plan to identify the community-based services needed and a strategy to develop needed local services. Needed services range from professional clinical and psychiatric consultation to respite and therapeutic foster care. Currently, if a need is identified that is not available in the community, the flexible funds are used to purchase the services from an off-reservation entity.

Services provided by *Sacred Child Project* are:

1. Wraparound care coordination and training
2. Parent advocacy
3. Parent and community education
4. Tutoring
5. Mentoring
6. Traditional healing
7. Recreational activities
8. Cultural activities
9. Psychological services and assessments
10. Transportation
11. Limited family emergency financial assistance
12. Youth social development activities

The *Sacred Child Project* strives not to replicate the existing medical and mental health models, but to integrate mental health services into the community and tribal culture. Families drive the process; clinical services do not drive the families. This is the primary reason services are tailored on an individual basis to each family.

In addition to these services, there is long-range planning for community services. *Sacred Child Project* continues to network and collaborate with key players in each community to build a comprehensive system of care. It has meant building on existing resources as well as starting from scratch in other areas, such as the partnership with the Native American Children and Families Services Training Institute (NACFSTI) and the Tribal Colleges at each of the North Dakota reservations. Not only has a mechanism for long-term training on the wraparound process been established with the training institute, but also long-range planners have begun to work in partnership with the training institute and the tribal colleges to develop mental health paraprofessional degrees at each site. To paraphrase Dr. Terry Tafoya, a noted American Indian psychologist and consultant to the *Sacred Child Project*, "I can train someone to become a clinical psychologist in ten years; it would take me a lifetime to train someone how to be an Indian."

WITH EAGLE'S WINGS

With Eagle's Wings is a culturally appropriate program to deliver wraparound services to children, youths, and their families, located on the Wind River Reservation.

The Wind River Indian Reservation is located in west-central Wyoming and is home to the Northern Arapaho and Eastern Shoshone Nations. It is geographically the second largest reservation in the United States, stretching 70 miles east to west and 55 miles north to south. Approximately 3,000 Shoshone and 6,300 Arapaho live there.

As is common with reservations, the Wind River Indian Reservation is geographically isolated. There are many challenges. Unemployment ranges from 68% to 85%, depending on the season, and the majority of households have an annual income of less than $10,000. There is a lack of available, affordable and adequate housing. A recent survey of reservation homes showed that 60% are in need of major repairs. Even though extended family units are often preferable, overcrowded homes (due to hardship, not as a result of choice) present mental health issues for family members. Substance abuse results in family disruption and is a factor in almost all reservation arrests and most of the involuntary commitment cases.

Because parents are one generation removed from forced removal of children to federal boarding schools, intergenerational grief and victimization remain largely unresolved. There are, however, many strengths. There is a rich blend of cultures. Both tribes hold Sun Dance ceremonies and powwows during the summer months. Culture classes are taught in the schools. Both tribes have their languages, and although they are not widely spoken, there is a renewed effort to revive them. There is a blend of traditional spirituality and Catholicism.

The two nations that now reside on the Wind River Indian Reservation were each promised separate reservations. But while the location of a reservation for the Northern Arapaho people was being decided, the federal government obtained permission from the Shoshone people to allow the Arapaho to temporarily reside on their land. Promises to the Arapaho people were forgotten when a new administration came into the White House, thus leaving them on the Shoshone Indian Reservation. The government recognized the land as jointly owned by the two tribes and changed the reservation's name to Wind River Indian Reservation.

The reservation was established by the Fort Bridger Treaty of July 2, 1863, and included sections of Colorado, Utah, Idaho, Montana and Wyoming. A second treaty, signed July, 1868, established the reservation at its present location.

Mission

Since the project is new, the mission statement is still under development. The project's philosophy is that children with severe emotional disturbance can best be served within their local community when adequate support for the caretaker is provided by wraparound services to ensure that the child's needs are met.

Program Description

With Eagle's Wings is in its first year of the grant from the Center for Mental Health Services (CMHS) and is operated under the Northern Arapaho Nation. The program is the first tribally controlled mental health program on the reservation. The grant was written in dedication to Anthony Sitting Eagle, a principal chief of the Northern Arapaho people who died in 1997.[2]

The program presently serves children and families who are referred or who are "walk-ins"; staff are doing intakes in anticipation of providing a full array of services. Nevertheless, 504 children ages ten and under have been served at Welcome House, the project's facility designed to protect children from abuse, neglect and domestically violent situations. Welcome House is a proactive and preventive response to child abuse. Crisis shelter is available when the following is needed: (1) respite care; (2) a 24-hour site placement for children referred by law enforcement and social services in response to abuse and neglect in the home; (3) 72-hour care for children whose parents are engaging in active chemical use/abuse; (4) 24- to 72-hour safe care program for children from families in which domestic violence is anticipated or occurring.

Another component of *With Eagle's Wings* that is in operation is the Young Warrior Society, a cultural group for male and female youths to instill pride, independence and self- esteem. The Young Warrior Society is facilitated by young adults and is guided by tribal elders and spiritual leaders.

When *With Eagle's Wings* is fully operational, the program will include:

- Diagnostic and evaluation services
- Individualized service plans
- Outpatient mental health services
- Case management, case coordination and in-home support services
- Intensive home-based services
- Emergency 24-hour services
- Transportation support
- A cultural program
- Therapeutic foster care through the resources of Wind River Children and Families Program and Fremont County Counseling Services

The Operational Services Teams (made up of staff who are responsible for the care of the consumers) are multidisciplinary and use program models that echo the traditions and beliefs of the American Indian cultures on the reservation. These include reinforcing the identity of a child in relation to his community, full inclusion of family and significant others in goal setting, and case management that focuses on the individual's strength in response to challenges.

The Community Mental Health and Development Board has responsibility for obtaining the array of wraparound services needed. The strong cultural components will ensure culturally competent training for all service providers and staff, individual support through tribal elders and traditional healers, and access to spiritual healing practices.

MNO BMAADZID ENDAAD "BE IN GOOD HEALTH AT HIS HOUSE"

The Sault Ste. Marie Tribe of Chippewa Indians is in partnership with the Bay Mills Tribe of Chippewa Indians and Hiawatha Behavioral Health on this services project. The Sault Ste. Marie Tribe, located in seven eastern-most counties in the Upper Peninsula of Michigan, has approximately 27,700 tribal members. The Bay Mills Tribe is a small, isolated rural community of 1,245 tribally enrolled individuals located in the extreme northeastern end of the Upper Peninsula. Hiawatha Behavioral Health serves three counties with a total population of nearly 52,000. Those three counties encompass close to 3,500 square miles, and many areas are only accessible by ferry, boat or plane.

Mission and Philosophy

Since the project is new, the mission statement and philosophy are still under development. The mission statement will be compatible with the vision statement of Anishnabek Community and Family Services.

> *"To develop an integrated, seamless and multidisciplinary service delivery system that provides for appropriate, culturally sensitive services. It shall be designed for the prevention and early identification of child abuse and neglect. Services shall be client oriented, easily accessible, and focused toward measured positive outcomes..."*
>
> *"Objective 1: The development of a seamless health and human service delivery system inclusive of multiple systems that will emphasize prevention, early intervention, and coordinated services to improve access of services to Native American children and their families.*
>
> *"Objective 2: To provide non-native service providers with information and training regarding the cultural norms and practices; specifically, parenting, family values, and norms.*
>
> *"Objective 3: To educate the community to the needs of children with serious emotional disturbance and their families and availability of services to ensure that all children are provided a safe and nurturing environment in which to grow."*

Project Description

Mno Bmaadzid Endaad, "Be in Good Health at His House," is a program that blends tribal tradition and values with mainstream expertise. Collaboration while maintaining cultural integrity is the foundation of this program. Although young and not fully implemented, *Mno Bmaadzid Endaad* is integrated into the Indian communities it serves. It has an extensive web of collaborators in tribal and non-tribal programs of human services. *Mno Bmaadzid Endaad* is a model for multidiscipline collaboration, which becomes the focal point for their system of care.

Staff are committed to promoting spiritual healing, using grassroots mentors, and capitalizing on the use of their elders and community members who, reflecting the deeply rooted traditions of community before individual welfare, generously give of their wisdom and time. *Mno Bmaadzid Endaad* staff foster this commitment by modeling this same generosity of self.

Like most Indian, community-based programs, *Mno Bmaadzid Endaad* staff are available far in excess of their scheduled hours. Staff include both professionals and paraprofessionals, natives and non-natives.

Mno Bmaadzid Endaad is fortunate to be part of an established network of agencies within their service area. A variety of tribal programs, such as tribal schools and substance-abuse treatment programs, are additional resources and part of the system of care with which *Mno Bmaadzid Endaad* collaborates.

Notes:

[1] The 12 domains are residence/housing, family, social, behavioral, educational, safety, legal, health, crisis, spiritual, cultural, and financial.

[2] Anthony Sitting Eagle (Indian name was Chief Yellow Buffalo—7/27/27–2/2/97) was a spiritual man with great insight into Arapaho culture.

Chapter VI–Findings and Discussion

INTRODUCTION

In keeping with American Indian tradition and practice, stories should be passed on from generation to generation, for within stories lie deep meaning and significance. To this end, the interviews at the five American Indian sites, although guided by a series of questions, encouraged the telling of personal stories. The participants were interviewed at length and in person by interviewers who asked questions and then were silent for long periods of time. The intent was to give the participants an opportunity to tell their stories in a manner and at a pace that they controlled.

The questions were designed to reflect the "relational" or "circular" worldview,[1] in contrast to the linear worldview held by most members of American society. They were designed to elicit information that would enable us to evaluate whether or not there was a positive move by individuals, families and communities toward achieving a state of "balance" or harmony. Wellness is achieved when the complex interrelationships in a person's life have been positively affected so that the broad and overlapping realms of context, mind, body and spirit (the four quadrants of the medicine wheel) are in balance.

As illustrated in the previous chapter, the five American Indian Center for Mental Health Services grantees are in varying stages of program development, serve diverse populations, and structure their programs differently from one another. Despite these differences, the comments from the family informants are remarkably similar. Information from the program personnel differ chiefly in their program descriptions but very little in their discussions of the needs of their constituencies or the effectiveness of their services.

In reviewing the responses of each site, we identified several reoccurring themes. The themes often cut across two or more quadrants of the medicine wheel, as do many of the responses. The themes revealed 18 identifiable promising practices that address the integration of culture as a resource for helping children and their families. The promising practices include:

- Use of extended family and the extended family concept (context)
- Use of traditional teachings that describe wellness, balance, and harmony or provide a mental framework for wellness and use these as objectives for the families (mind)
- Use of specific cultural approaches such as storytelling, talking circles, ceremonies, sweat lodges, feasts, etc. (mind, spirit, body)
- Use of cultural adaptations to mainstream system of care practices such as wraparound, respite, crisis intervention, collaboration (mind, context)

- Use of cultural restoration, via mentors, groups, crafts, (context, body)
- Use of methods to promote healing of Indian identity and development of positive cultural self-esteem (mind)
- Use of methods that build connection to community, culture, group, clan, extended family (context)
- Use of methods that build up the sense of dignity and strength (mind)
- Use of methods that invoke the positive effects of spiritual belief or tap into spiritual strengths or support (spirit)
- Use of elders or intergenerational approaches (context)
- Use of methods that prepare children to live in two cultures and cope with racism, prejudice (mind, context)
- Use of helping values from traditional teaching, such as 24-hour staff availability (context)
- Use of conventional and cultural methods to recognize and treat historic cultural, intergenerational and personal trauma (context, mind, body, spirit)
- Use of approaches that strengthen or heal the community (context)
- Use of the native language (mind)
- Maintaining an alcohol- and drug-free event policy, and dealing with substance abuse (mind, body)
- Incorporation of a value of respect for diversity within the tribe and exercising that value in services
- Use of all of the above alongside conventional services such as counseling, therapy, and health care (mind)

As stated in Chapter II, placing the responses into one particular quadrant facilitates discussion within the context of this model, but the boundaries between the quadrants are fluid. For ease of evaluation, responses and themes were categorized according to the four quadrants of the medicine wheel. Throughout the remainder of this document, you will read quotes from the participants in the interviews. These will appear without references to status (parent, child, staff, etc.). Responses have been edited only to preserve the anonymity of the family informants.

Context

Theme 1: Community as Context for Services

Across all five sites, as was emphasized by family members of all ages, staff, and all other informants, the theme of the community as the foundation for services stood out as one of the most critical components of context. The reasons given for this emphasis on the community included the following:

- "...[We] felt that identity was a problem for many of our people," and providing services within the context of their own community enhanced the client's identity as an Indian person. Staff and clients believe that this was equally true and equally important for the children receiving services, their families and for the community as a whole.

- "It just works well with everything else that's already there." Within each Indian community exists a wealth of human resources: kin, elders, medicinal and spiritual healers, people fluent in their native language and, often, other human services programs. All these resources are available as helpers to the children and families receiving services.

  "It has always been expected that all would take care of the children; it's a communal way of life. This is a premise for the program, that community and extended family are the same...Community members are willing to take on the most difficult issues, mental health issues, drug abuse; and because people see the community as theirs, they all take responsibility."

- Community-based projects foster community empowerment. As one of the spiritual people interviewed said:

  "It [funding tribally based programs] says, we [the funders] respect your [Indian people] ability to take care of yourself; we honor your integrity. This respect in turn helps teach self-respect to our children—they see Indians taking care of Indians, family taking care of family, and they see the old values being restored instead of the view fostered by the BIA [Bureau of Indian Affairs] of Indians as children who aren't capable of taking care of themselves."

- The familiarity of community-based programs engenders trust and thereby increases utilization and receptivity of interventions: "Before I wouldn't ask for help and I do now...I wouldn't go out and ask anybody else."

- "The provider has a role in the community…community takes care of each other; community is in the heart and mind…" The staff of these Indian projects have a deep love for and commitment to their families and communities. This is unlikely to occur within programs developed by outsiders.

  "It is a 7/24 day job. The provider has a role in the community, one type of healer. The cultural expectation of that role is that of 'healer' as much as 'turtle' is 'turtle;' turtle does not stop being a turtle at 5 p.m."

- Accessibility is increased enormously.

- There can be great flexibility in programs that are community-based, particularly when compared to programs stemming from large, multi-program organizations or government bureaucracies. One staff person said, "I call it creative financing. I find ways of justifying expenditures or activities that will really benefit the clients."

- Cultural competence is more attainable in community-based programs. The five projects were designed to incorporate traditional values that may conflict with mainstream values: "In a Navajo context, the split between family and provider has little relevance." In mainstream mental health programs, preserving clear and distant boundaries is fundamental to good practice. In Indian communities this practice would be considered antisocial; it would invoke suspicion, perhaps fear.

Promising Practices

All sites use the community as the base of operations for services. Since most staff are members of the local communities they embrace traditional values about access to help. This allows for 24-hour availability. It allows staff to become involved with the families they serve at an intense level; this, in turn, facilitates the growth of the family members. Community ownership of the project enhances dignity, cultural identity and cultural self-esteem.

Theme 2: Collaborative Partnerships as Part of a System of Care

Although basing programs within communities is viewed as a prerequisite for effective services by the providers and consumers of these five projects, none of the informants sees their projects benefiting from existing in isolation of the services and partnerships available off-reservation. Collaboration and partnerships are seen as enhancements to community-run services. In the mainstream world of human services, program personnel view native services or cultural competence as enhancing mainstream services.

All providers acknowledged their need for multidiscipline partnerships to create a system that meets the diverse needs of their children and families. This includes partnerships within the tribe, between Indian and non-Indian organizations, and on local and national levels. Respondents across all sites emphasized that Indian communities must be the hub of these partnerships. The children and families participating in the five projects appreciate the contributions these partnerships make in their lives. They appreciate both the internal and external partnerships. Collaborations with residential treatment, child protection, juvenile justice, schools and mainstream mental health services are taking place at all these programs. *Kmihqitahasultipon*'s telepsychiatry program exemplifies the power of effective, collaborative relationships.

> *"It's real hard to take care of a medically needy child...parent needs lots of support...there were long trips to* (city) *to take her to the doctors all the time."*

> *"Treatment teams are multidiscipline teams providing wraparound services with intervention plans developed by the needs of the child. Teams work with all aspects of a family's needs; for example, they may work with medical doctors, landlords, schools, and the juvenile justice system."*

> *"Some site visitors wanted to know about family involvement...[name of parent advocate] has gotten involved [in the family advocacy movement] on a national level..."*

Promising Practices

The inclusion of these partnerships into systems of care has direct and indirect benefits. The direct benefits are, of course, the concrete services that are provided. The indirect benefits are the contributions that these relationships make in terms of addressing the issues of distrust that have risen out of centuries of abuse and neglect from government and "well-meaning" social agencies. Framing mainstream system of care practices (such as wraparound, respite, crisis intervention, collaboration and partnering with outside agencies) within a cultural context, is building credibility for these previously devalued approaches.

Theme 3: The Challenge of Living in Two Cultures

Collaboration results in more effective services and enhances the clients' ability to be successful in their dealings with the world outside their Indian community. It helps prepare the children to thrive in both worlds, as well. Family members and providers are acutely aware of the need to prepare their children to succeed in two cultures.

> *"The boarding school experience was a common one...This experience had a dramatic effect on both their ability to understand the outside world, and their inability to fit back into their culture at home."*[2]
>
> *"Traditional Arapahos are not taught to be forceful," but the father wants "my kids to be Arapaho...not forget their heritage; learn to walk in two worlds."*
>
> *"In response to the question of why live on the reservation, or why try to reconnect if you have left? 'Because it is home and where our culture is.'"*
>
> *"The primary challenge is understanding and knowing the ways and traditions of Navajo and distinguishing that from the mainstream thinking. Since* K'e Project *staff provide interventions in two cultures, it is important for staff to be aware of their own identity and how they process this for themselves."*
>
> *"People all know stories of how hard it is when kids leave the community. When they first go to school away from the reserve they are an 'Indian kid' for the first time. In Washington County, although the population is small, the only complete separate culture is Native American (no Blacks, Hispanics, or other groups). The walls look less built up, but are actually more. This is the only group of kids in this area that has to face being different due to culture. Some of the barriers are less visible and more subtle but still just as powerful."*

Promising Practices

The projects are using methods that prepare children to live in two cultures and cope with racism, and prejudice. This is aided by practices that promote healing of Indian identity that has been damaged by oppression, and by the development of positive cultural self-esteem.

Theme 4: Multigenerational and Kinship Relationships

The traditional value, common to all American Indian cultures, of the welfare of the family and the community over the individual's desires, persists today. At all sites people have learned how to work to build a more responsive and interactive community that supports their own as well as other children. The projects have strengthened their community's commitment to this value and the traditional value of hospitality and reciprocity. As this is occurring, there is a revitalization of the intergenerational roles and kinship relationships within the community.

In concert with fortifying relationships, other age-old values are reinforced.

This is particularly identifiable through the increased activities involving storytelling. Storytelling brings together elders and children, again strengthening the multigenerational, traditional relationships of elders. This vital contribution to the rearing of the children enhances the elders' self-esteem. All of the projects exhibited this strong sense of extended family and relationships in which children are the responsibility of all.

The commitment to helping one another and these revitalized, intra-community relationships is manifested in many ways and reflects some of the many very exciting benefits of these programs. It signifies the communities' ownership of their responsibility for the wellness of their children. This ownership reflects the increased self-esteem within these communities, which in and of itself contributes to the growing wellness of the entire community, not just that of the children.

> *"Extended family members are brought in to do the service plan. Extended family actually goes beyond kinship. It can include godfather or godmother, for example. It includes aunties and uncles [not necessarily biological aunts or uncles but aunt/uncle defined by the type of relationship established]. Some are clan members."*

> *"My mother was one of 11 children. I have over 100 cousins. We work with our own relatives."*

> *"The parent coordinator becomes involved and becomes like extended family. This is the way it was done in the past. When a staff member leaves, it is like abandonment."*

An elderly woman has been a foster parent to over 100 children.

An elder feels "urgency" to tell her story and share her knowledge. "I always wanted to give advice, but no one ever asked before. There was no forum to do so before, but now the program offers opportunities for sharing."

> *"I [a cultural specialist] am involved with the program because I can almost predict what will happen in the future for our Indian children. They will grow up not knowing who they are, why they're here, what their goal in life is."*

> *"The Young Warriors program used tribal volunteers as storytellers for cultural enrichment. People are really enthused about this program. Sixteen year-old boys really listen. Why? Because different speakers, elders, former councilmen told them stories, who they were, what's expected of kids of that age. There was a mix of boys, some good kids, some had trouble with drugs, or shoplifting, or other, but they're all here as one. That's what I like about the program. Sharing stories, especially, helps kids. They like that. The program is growing fast."*

> *"The program uses extended families by hiring family members as staff." (This is one of the promising practices that is a recent addition to some mainstream programs.)*

> *"It has always been expected that all would take care of the children; it's a communal way of life. This is a premise for the program that community and extended family are the same...The respite program helps utilize the extended family better ... Children or families can go to any adult or any family or to the health center. The emergency system doesn't need telephone numbers; first the family, then find another person in the community."*

> *"Because of the closeness, you can depend on your neighbors. Everyone looks out for the children. If you run out of butter, you can go next door. You can go from house to house for meals, and where you are is where you get fed."*

> *"Connectedness is the strength and sometimes the weakness. There are no secrets. Everyone knows everything. A teen who does something wrong finds that five people will tell Mom before you get home."*

A grandmother shared that when things went badly at home, "Elders would go to a home and be there. This was not saying that families are pathological, or have diagnoses, but that when people are in trouble, those they know and who care about them will be there until a sense of balance is restored..."

> *"Elders are meant to be with the children. This is their cultural role in society. Grandmas, great aunts, raised the children versus mothers and fathers."*

Promising Practices

The community as a resource has always been one of the greatest strengths of American Indian communities. The use of multigenerational and kinship relationships taps into the values and strengths of the community, builds positive identity, enhances cultural self-esteem and contributes to the dignity of the family.

The projects use methods that build these connections between families and their communities. They also employ practices such as story telling, which bind people in a common experience and are often therapeutic or instructive about how to live.

Summary

> *"When people are in trouble, those they know and who care about them will be there until a sense of balance is restored."*

In the social realm, the projects were found to have revitalized key cultural elements already in place. These include the extended family network and the unique strengths of the local communities. Both of these elements are abundant in American Indian communities; but, at the same time, these elements can be inconspicuous at the official program level. Within the context of their local community, project staff identified natural helpers and traditions, which became the foundation from which to build. For example:

Passamaquoddy uses extended family members as natural respite caretakers. This derives from their tradition of three elders going into the home of struggling families; by their presence of helping, the situation calms, and the family is able to recoup their own coping skills.

The Navajo project uses their ancient belief system of K'e (which traditionally defines relationships and responsibilities among family and community members) as the driving force behind all aspects of their work with Navajo families.

The *Sacred Child Project* tailors the balance between tribal beliefs and the wraparound model to each individual site in North Dakota. An example of responsiveness to the needs and preferences of Indian children and families, the *Sacred Child Project* realizes that a program approach of "one [Indian] size fits all" would not be respectful of, nor effective with, the multiple tribes and communities they serve.

The Sault Ste. Marie (Chippewa) site brings extended family members into the service plan, going beyond mere kinship ties. In recognition of their broader social context, aunts and uncles (identified by type of relationship established, not bloodlines) or clan members might be part of a child's service plan.

The Northern Arapaho project was built with the leadership of highly respected tribal members who saw a need and did something about it. From this, a ground swell of concerned tribal members—young and old, male and female—volunteered to help build the program.

Mind

Combining the medical and emotional components into the mind quadrant reflects the knowledge that American Indian cultures have of the inseparability of these components of wellness. This holistic concept has an impact on the projects' activities as well as the goals set by project personnel.

This quadrant cannot be discussed without pointing out its relation to all the other quadrants. You will appreciate the relatedness of the body, context and spirit quadrants as you read the informants' comments addressing the area of mind.

Theme 1: Historical Oppression and Post-Traumatic Stress

Within the past several years Western science has produced an abundance of evidence on the impact of trauma on the developing brain of the child. The disruption of the brain's biochemical system that occurs with persistent childhood trauma is a frequent occurrence within Indian communities. At every site, every staff member, spiritual person, and parent, and most of the older children talked about the impact of trauma in their lives. Trauma occurred as a product of multigenerational oppression, massacres and relocation, as well as through physical, sexual and emotional abuse informants suffered in current generations. The relationship of today's suffering to the historical oppression was emphasized by informants across all sites.

A mom who was born on (reservation name) reported that during the time when she was growing up, she helped her mom raise her sisters' children, as her sisters kept running off and leaving their kids and getting in trouble...Her mom died when she was a teenager. "I felt all alone, didn't have anyone to turn to." She told how she tried to take care of her dad, but finally gave up and turned to alcohol. Her dad died. She has many children, and her husband died several years ago when she was pregnant. Some of her children were evaluated as having Fetal Alcohol Syndrome. "I had a lot of pain that I had to endure. I had called and reached out to a lot of people, but I had a hard time getting that support."

> *"Sometimes it gets so bad, you have to cry."*
>
> *"Non-Indian mental health workers don't understand where these kids are coming from. I understand, I know the hardship they have gone through when they were growing up."*
>
> *"The program offers comfort. I'm just comfortable with the staff. Staff are concerned, trained, really listen, and try, looking in all directions for the problem. It's really a trying program."*

"Without this program I would be overstressed, no time, abusing. I don't know to what degree, probably all degrees. It would be a big mess. I think, 'cause when you grow up and you have issues and then you have kids, such clashing goes on. It's very hard to parent when you have been parented in ways you shouldn't have, and then you turn around and try to parent your kids, and it falls apart right before your eyes."

In one group there was considerable discussion about personal pain:

"You can't start to heal until you can talk about it without crying."

"Love, humor and hope are needed."

An elder's advice: "Keep talking about it until you can talk about it without crying. Then you can begin healing."

"Parents have to be the backbone, but need support."

A dad was sober for over 40 years and still feeling guilty because of all the pain he had caused in the family. The "mom does not want dad to have any fun for all the pain he caused when drinking 40 years before."

"NANACOA (National Association for Native American Children of Alcoholics) is helpful as a resource, encourages going back three generations for 'healing journey.'"

Promising Practice

All sites identify post-traumatic stress resulting from historical oppression and multigenerational trauma as a major contributor to mental health problems. Because of their shared tribal histories, there is a profound understanding of the causes of distress and an equally profound commitment to heal. Projects use culture and history as part of their healing strategies. They use spiritual healers when appropriate, and they use community helpers, such as the parent coordinators in the Sacred Child Project and mentors from Kmihqitahasultipon

Theme 2: The Cultural Connection in Fostering Wellness

In the Context section of this chapter, we talked about the importance of cultural traditions and revitalization as an essential component of the context quadrant. From the following, you will see the relevance of culture in addressing the mind quadrant. You will see how culture provides the foundation for learning and healing. As one site director described it, "Part of this project is a restoration of our culture."

Language

"At one time only four women and five men knew Arapaho. The Arapaho made the Bambi movie in the Arapaho language (1994) and everyone enjoys it. 'I don't even understand Arapaho, but it was cool.' You need to see it in English first, then you understand it. It's a fun way to learn the language."

A little son tells Arapaho stories that his grandparents tell him at school. "It's just awesome to watch him, even the expressions on his face, really fun to watch him."

*"When we started this program, it started in English. We went to sacred grounds and ended up with people talking in Passamaquoddy . That happens in staff meetings too. In the [*Kmihqitahasultipon *Program] elderly people can get services for the first time, because we have services in Passamaquoddy [language]. This is the only part of the health center where staff meetings end up in Passamaquoddy [language]."*

"The Passamaquoddy language was only written down for the past 25 years. The language changes with each generation, but it is still the same. We add on to it, not taking anything away. Everything worth having evolves. It is important to put things in a language that suits us. We teach it every day by speaking it. I grew up speaking Passamaquoddy and learned English when I went to school. In this community I was encouraged not to be ashamed of who you were, even though there was a conflict with the school and church, which was the same, a parochial school."

"This place has stood 12,000 years. People have looked on the same lake for 12,000 years, through 400 years of acculturation. And we still have the language. People can still do things. The program reflects that back and allows people to see what it is and how it looks."

Storytelling

Storytelling inspires adults. "Dad now wants to tell stories to his kids, and to his own mom."

A story was told of an Arapaho laying a stick by a baby. "You leave for a minute, the stick is a weapon for our people. Even though the baby is an infant, the baby has the spirit of an adult, and the baby knows when you tell it that you love it. It knows when it's not wanted. The stick is a weapon in case there is another spirit wanting to take the baby away. As long as there is a stick by the baby, we feel the baby is being protected."

"We all tell stories, talk to clients in terms of stories; it is part of the melody. New mental health staff, when they come here, have to adjust to a community of storytellers, the memories come back and staff meetings end up storytelling sessions. We don't even realize we are doing it, but that's how we communicate 'cause it's natural; that's how we're brought up."

Education

"The tribe is also considering developing a community college." (Some tribes where the projects are located do have their own community colleges.)

"The way we learn is not through theory but rather through example."

"During her growing-up years respect was taught from the beginning."

In the Kids' Camp team-building exercises were used; they were "hands-on versus lecture. It is leadership building. It keeps kids interested. This is mental health promotion and prevention at the same time, including substance abuse prevention."

"I was invited to go along with the staff to their training. I take the training home and use it with other families in my community...I see a lot of children who would benefit, especially from the cultural side. The strength of Sacred Child is that they listen to parents and parents have a say about what goes on."

Mental Health

A staff person from one reservation Indian school said: "There are three counselors in the Indian school. Two are Anishnabe. They make referrals to the Sault Ste. Marie program."

"To reach kids who need help, you have to reach them with what is familiar and comfortable for them. Lack of permanency [in programs because of funding] is a big downfall. There was a teen coordinator just for teens; it used to be a position, but federal funding ceased, so this program did as well. The coordinator did drug prevention, self-esteem enhancing, mental health fortifying. There were teen dances."

Cultural Activities, Strengths and Traditional Concepts

The use of cultural activities to expand the strengths of projects' participants is a promising practice that has been in use for centuries. Indian people do not label this practice as "therapeutic" but acknowledge that it provides that benefit. Crafts, ceremonies, sweat lodges and language promote increased self-esteem as they fortify people's identity as American Indian, strengthen their spiritual foundation, and revitalize the community as one entity.

> "Sacred Child *helps foster [this] cultural renewal. We bring the players together and have started these things up again as part of creating an environment where children can attain a sense of balance, sometimes for the first time; and their deficits are not focused on, but what they have to offer. And they receive a lot of encouragement to be part of this proud process, and they buy into it."*
>
> *"It's good to see the effects on the children. Kids were amazed by the drummers. I need to get my family to the groups put on once a month by the program."*
>
> *"It's just natural. Everybody that works here [Kmihqitahasultipon] is native. It's normal once in a while to go to a ceremony as a family; we do some smudging, sweat lodge." (It is important to note here that not all staff are American Indian genetically. The non-Indian staff have become part of the family and are thus considered as part of the community.)*
>
> *"There are little incentives the program puts out there to lure the parents. They encourage the sweat lodge, socials, talking circles for children, parents, adults."*
>
> *"We make rattles, have a specific drum-making class. When the kids made the instruments an elder came and played a song on each of those instruments as the first one played. Some mentors are master craftsmen."*
>
> *"The basket makers' alliance held a workshop. Kids from generations of basket makers, their hands just moved to make baskets. People hold dear these crafts; this is getting more true with time."*
>
> *"The way to teach family wellness is through the restoration of K'e and Navajo teachings (clans, values, family, role, kinship, morals, etc.). Values and beliefs are based on the clan system, how Navajos identify themselves."*

> *"An elder explained to providers and families that the concept of K'e is already there, so rather than working against K'e like outsiders would, people should work with the concept of K'e where families already have a place."*

> *"The* K'e Project *oversees a large geographic area and provides home-based services to people in rural areas. This creates a barrier to services, so that in some isolated areas teams can only visit one home per day. As the team enters the home, they introduce themselves by their clan. This promotes the Navajo way of thinking and allows the family to culturally identify with the team members."*

According to a staff person, the greatest benefit of the project is "that our culture and our language and our system of K'e really does work, and that an agency actually acknowledges that and is using it. That is building the self-esteem of individual families and the communities."

An aunt reports taking care of her nephew with severe, chronic mental health problems: "He did not know anything about his culture. He had been in group homes. My first cousin is his mother, so I am really his auntie. In our culture that is like a second mother. We take him to ceremonies. We practice our ways in our home, with ceremonies at the house. He has been in our home for eight months. We are his extended family. The care coordinator…came to the house frequently to help him settle with us and talk out his problems. They came frequently at first. He did not know who his dad was. This is helping me stay sober…"

> *"The project reaches out to the schools with cultural presentations. Bringing educational programs to the larger community promotes well-being in the community and acceptance, which contributes to harmony within our community; as it lessens the antagonism outside. We provide them an opportunity to display our cultural differences and have the result of that experience yield a sense of pride for the children versus the shame our parents and grandparents experienced. It seems to be taking effect in this generation coming up."*

Promising Practice

The incorporation of cultural strengths, practices and teachings into community mental health is an important promising practice that reaps many benefits. Storytelling, fortifying the role of elders within the community, restoring the culture and increasing the number of people who speak their native languages are all promising practices. One of the most important promising practices is the use of traditional teachings that describe a state of wellness, balance, and harmony and that provides a mental framework for how to get there. The families are then adopting the definitions of health described in these teachings as their own objectives. These practices contribute to the healing of Indian children, their families and their communities. The use of physical activities to help overcome the physiology of depression, increases self-esteem and provides alternatives to substance abuse. These are additional promising practices that impact treatment and prevention.

Theme 3: Empowerment, Parenting and Other Systems Strategies

The project descriptions in the preceding chapter show some unique strategies in systems development that use both internal (tribal) and external (non-tribal) resources. Although not all aspects of the projects were described in full and not all five projects have fully developed programs in place, there are common objectives. These include increasing parenting skills; encouraging individual, family and community empowerment; and developing an all-inclusive system that brings together every stakeholder in a child's welfare. The following quotes and comments by informants speak to these aspects of wellness.

> *"I would like someone to come in when I need it and stay at my house around the clock, to stay with me and show me, say 'Hey, I want you to do this.' Someone in my house from morning to bedtime, as long as it takes. When you've been abused so many years and when you have a child that reaches that age of what you really went through, it's very hard to not treat them like you were treated. You feel all those emotions going on, and you don't feel like you can control yourself. You either ask for help, and I pretty much did. I felt that's what could have helped me more."*

> *"One of the strengths of the* Sacred Child Project *is that the youth develop their own treatment plans. This gives them a sense of empowerment. They have control over their lives, even if they did not realize that before. I learned that their acting out was their way of asserting their own power, but it was not in a constructive way. Sacred Child gives them choices and since they choose without pressure, they buy into their own plan. It is truly their plan, not Sacred Child's."*

> *"We visit versus do an intake. We write down the words and phrases that they use, and those words get put into the case plan. Maybe they need substance abuse counseling, but you wait until they let you know they want it. At the* Sacred Child Project *you meet them on the human level, and they share their pain on their own time frame, which could be weekends, middle of the night. The process changes, and they eventually do not need you any more."*

> "Sacred Child *respects the families that do not go traditional. The process respects that."*

> *"...had been in foster homes...Care providers put out cards with different things that could take place. He was to choose the things he wanted to work on. Sacred Child put the selection of cards out. The first thing he grabbed was the culture card. This was how they developed a care plan. First things he took were to speak his own language. There are 12 life domains. The cards are from those domains, and the child and family choose what they want to work on."*

Promising Practices

The use of cultural adaptations to mainstream practices (such as wraparound, respite, and crisis intervention) encourages parents and extended family members to become intricately involved with the care of their children. In turning over the responsibility for developing the components of intervention strategies to families, as takes place in the *Sacred Child Project*, projects are revitalizing the traditional role and connections of family and contributing to the dignity of the family. Teaching of traditional parenting skills restores cultural strengths and builds a positive sense of cultural identity.

Summary

> "Sacred Child *allows us to voice our own opinions and say what we believe can help us. It gives us a lot of hope and teaches us to believe in ourselves again. It identifies strengths that we did not know we had. Culturally, the children are bringing the* Sacred Child Project, *the culture, to the community...Parents participate to help the children, and then help themselves. It is our children that are leading the way. We didn't tell them. They have chosen this, but it had to be presented to them."*

Accommodating the American Indian worldview, which is different from that of the majority society, means that many aspects of program approaches for an American Indian community must be tailored to the specific tribal community served. Service providers need to know about the specific tribal histories of their clients. The historical oppression of American Indian communities and their exclusion from the process of change have led to long-standing feelings of mistrust and powerlessness of American Indians. Staff, parents and spiritual people at all five projects related stories of their experiences in developing a strengths-based, community-empowering program within Indian communities who were long taught to, as one parent said, "to not feel, but endure."

Although the projects are in different stages of maturity (ranging from a five-year-old project to first-year projects), each has been able to help parents transition from positions of frustration, and at times hopelessness, to positions of strength and empowerment. Their success in engaging families in the community-building process is based on their inherent knowledge of the communities and their ability to partner with families. Together, parents, community, staff and tribal leaders designed services for children with serious emotional problems that are based on mutual acknowledgement of the intellectual and cultural power of the communities in which they live.

One parent stated, "The program gives us a lot of hope and teaches us to believe in ourselves again. It identifies strengths that we did not know we had." Another parent echoed this sentiment in his description of available services before the grant, "Usually it is not how healthy you are, it is how bad you are. From our meetings (now), I found out I have a lot of strengths. I see a lot of strength in my son now. I didn't know I was blinded to my strengths. I just thought I didn't have any."

The program sites also demonstrated, across the board, that individual wellness is measured in the context of community wellness. Interdependence within tribal community resources of family and tradition continues to be emphasized, as opposed to a goal of promoting independence. In addition, all sites target services toward a restoration of balance, as opposed to directing services toward a specific set of symptoms.

The concept of community serving community is full of strengths and challenges. For example, the shared tribal or community experiences of staff and families lead to clear understanding of the subtleties and complexities of troubled children and their families in Indian country...In addition, the often-hidden strain on American Indian staff who face community pain daily, in which they too may share, is a difficult position and there is little rest.

Body

For American Indian cultures, for whom wellness is a holistic concept, programs addressing physical wellness are common. Staff at all five projects articulated their awareness of the importance of medical wellness as a part of mental or emotional wellness. Indian cultures have always acknowledged the body/mind connection. They are aware of the importance of physical exercise in combating depression and anxiety. They recognize the critical importance of nutrition in controlling diabetes and high blood pressure, diseases that occur in higher-than-average proportions in American Indian populations. They are aware of the part these diseases play in emotional illnesses such as depression and anxiety.

The five projects encourage physical activities, and project staff participate with clients in camp-outs, sports, dancing at powwows, and other activities. All the activities are drug- and alcohol-free, and some are tobacco-free (except for ceremonial purposes) as well.

Physical activities are used to fortify family, peer and other community relationships, combat depression and expand horizons (context quadrant) of the youth. They are prevention as well as treatment tools.

Theme 1: The Mind/Body Connection

The presence of Indian health clinics, often co-homes for health and behavioral health programs, on most reservations provides a natural partnership in the creation of a system of care for children.

> *"We are housed in the Indian Health Center. This health center belongs to this community; all services are here, and people come to get their whole needs met."*
>
> *"You can look at this place holistically. The health center is designed to serve this community...It is about putting together mind and spirit."*
>
> *"People who come here don't have to make choices about services. There are no divisions; they can't fall through the cracks."*
>
> *"People are treated holistically. They take good care of themselves, make use of medication for medical needs, use medication and diet for kids with behavioral problems, and get involved in cultural programs."*

Promising Practices

Collaboration between the projects and medical services are demonstrating that use of the cultural approaches, integrated with conventional services such as health care, help address the whole person. This integration of cultural approaches and conventional Western approaches means that families have choices and can take the best from both worlds. The relational worldview as applied here means that staff members take an active role in ensuring that the medical needs of the participants in their projects are addressed. These promising practices are parts of the wraparound system of care that the projects provide and positive examples of the cultural adaptation of a Western model.

Theme 2: Physical Activities

As parents and children talked about their experiences with physical and sexual abuse, they described depression and the inertia that often accompanies major depression. They talked about how attending activities, such as the camp-outs and powwows, helps them to break the isolation in which they find themselves. They also said that the physical activity makes them feel better, helps them expand their repertory of appropriate behaviors, and promotes healthy relationships. Craft activities also provide the same therapeutic benefits, while at the same time they build fine motor skills, thus filling what is frequently a great need of children with neurological disorders.

> *"The Hiawatha Behavioral Health Respite Program is a yearly camping trip for SED [Seriously Emotionally Disturbed] and developmentally disabled children. There is overnight camping, canoeing, campfires. One purpose is to provide 'normal' activities to children with special needs."*

One teen reported on the Kids' Camp he attended: "There is theater acting, dance, storytelling. It all teaches appropriate behaviors, how to relate in a good way. It occupies time, so it keeps interest up for productive instead of self-destructive choices."

> *"I taught my son. We go to powwows, and he knows lots of dances like the Snake Dance, the family dance. My daughter does the pageants. They're right involved; they love it; it's been there; the program encourages it; the respite parents take the kids when they can."*

> *"Powwow is a gate usually for many people to learn about the culture. The tribe needs a firm plan for children learning culture as a prevention tool."*

Promising Practices

The use of physical activity, dance and sports to promote prevention and provide treatment is accomplished through several promising practices. The activities described by the participants are very complex in that they are working on several levels. Gathering for sports or traditional dancing can strengthen or heal the community. For many, traditional dances are methods that invoke the positive effects of spiritual beliefs or tap into spiritual strengths. The activities restore cultural practices and values. This promotes the healing of Indian identity and development of positive cultural self-esteem. It builds connections to community, culture, group, clan and extended family. The teen and family camp-outs for healing demonstrate the effectiveness of one promising practice.

Theme 3: Substance Abuse, A Major Physical and Mental Health Problem

Substance abuse, acknowledged by American Indian communities as perhaps their most severe health problem, falls within the quadrants of mind and spirit as well as that of the body. Drug and alcohol-free activities are part of the mental health programs and all components of the system of care for Indian children. All sites have youth drug and alcohol programs and/or refer youth to treatment programs, including residential treatment programs. Two of the sites co-sponsor drug- and alcohol-free New Year's Eve powwows and help clients with expenses when needed.

(This story was told by a man in Passamaquoddy and then in English, who said his gift to his son is that his son has never seen his father drunk.) "A mouse is trying to get a cat to take him out of a beer barrel. The mouse says, 'If you take me out of this barrel, I'll let you eat me,' and the cat says, 'No, if I take you out, then when you dry out, you'll run into that hole.' And that's what happened. When the cat protests that the mouse said he would let the cat eat him, the mouse says, 'Well, can you believe a drinker?' This was one of the first stories I ever heard; it's more funny in Passamaquoddy."

> *"...[At the Kids' Camp] we put kids with healthy adults. There is no smoking on camp grounds. No drugs or alcohol. Kids watch their parents struggle with abstinence. This models the impact of addiction."*

Of the many families served by the *K'e Project*, one example may clarify its success: "Family members...had been in trouble for a long time. Their paper trail included juvenile detention, truancy, mom's alcoholism, and housing problems. After a year in the *K'e Project*, the mother became sober and began a positive relationship with a man. The children stayed in school and made drastic improvements, and the family was in a relocation home. One child was promoted to high school, and two made the school's honor roll. Although there were still problems after a year, the major family goal was to take each day to bless and respect their guiding spirit for healthy living."

> *"...New Year's Eve powwows; it started about eight years ago. It was sponsored by the Sioux tribe. It was in order to promote healthy celebration of the New Year free of drugs and alcohol. The families get together to promote a clean lifestyle. It is about the importance of living alcohol- and drug-free. Dancers are models for the children."*

Promising Practices

The campouts described above are promising practices that address drug and alcohol treatment and prevention. The physical activities are substance abuse prevention in that they provide constructive things for children, especially teens, to do. The youth articulated the need for these activities as part of substance abuse prevention. Projects are maintaining an alcohol and drug-free event policy (clean and sober powwows) and are actively dealing with substance abuse through special projects, community involvement, collaboration and public education. A good example of a special project occurred at *Kmihqitahasultipon*. *Kmihqitahasultipon* facilitated the production of a film against huffing. Tribal members produced the film in consultation with outside experts. Tribal youth were the actors. The process of making the film was therapeutic and educational; there are on-going educational benefits for the tribe as well.

Theme 4: Food

The sharing of food remains an important value of hospitality in all American Indian communities, and virtually always has a part in ceremonies, sports, social activities, and educational and therapeutic groups. It is a primary tool the projects use to expand their client base. Potlucks and meals provided by the projects draw in community participants; prayers are said before eating; and spirituality is brought into the activities in this manner as well.

Food was provided at all interviews and activities associated with these interviews as part of the acceptable protocol for such an activity.

> *"We had a recent national evaluation, and everybody in the community brought food."*
>
> *"Families would move from their lodge to their sugar camps; after sugaring, they would move closer to the shore for fishing."*

The sites reported that before contact with the Europeans, the medical problems of obesity, diabetes and heart disease did not exist. With the relocation to reservations and the commodities provided by the Bureau of Indian Affairs, people's diets changed radically. Despite the food provisions, hunger was a frequent experience. Some of the families talked about the history of poverty and the years of being hungry. Despite the poverty and hunger, people knew that they were a community, that they were family, and this still pulls them together today.

A story was told of "poverty when young…we were so poor we had no meat. but we knew we could go to relatives' homes and get meat."

A story was told of a boy with a counselor: "He was hungry, and she gave him a sandwich. The boy said he had to go home 'to change my shoes,' but he really took the sandwich home to his younger siblings."

Promising Practices

Using food is a cultural approach that is an important promising practice. It includes providing food, holding potlucks, sharing of traditional foods and incorporating spiritual teachings about foods and their use. Ceremonies often involve sharing food and have great healing ramifications with regard to physical and spiritual sustenance.

Summary

"I love to dance. When I go, I feel grounded, level headed; I know there is a peace and calmness inside. I know my world doesn't feel so crazy."

The relationship of the body to mental health is one of interdependence. Family and cultural norms around eating and drinking, as well as aspects of health, nutrition, and exercise, also affect the harmony in the life of a tribal member. Families and staff were able to remember incidents, within their lifetimes, of gross deprivation and multigenerational trauma. A common theme from adults was their overwhelming grief and their turn to (or return to) alcohol as a way to self-medicate and thus avoid feeling the buried pain of their past and present. For some parents, this incapacitated sense of physical wellness and balance compromised their ability to parent effectively.

Project staff and parents are well aware of the interdependency between the body and mental health and have found ways to strengthen both by working on physical elements such as diet, exercise, and recreational outlets, as well as medical needs such as diabetes control and substance abuse treatment. All of the projects have strong links with the medical health care practitioners, and the Passamaquoddy project is located in their Indian health center.

Due largely to services offered through these projects, families reported that they have rediscovered pride in their culture, have been able to stay sober, and have both found and become mentors. They are thrilled that their children have been able to avoid many of the problems they suffered as children; with their families' help, the children have been given opportunities to heal and learn how to cope in an increasingly difficult world. The emphasis on cultural strengths was central to all these programs. Staff used, and family members learned to use, stories, sweats, medicine cards, dances, drumming, basket-making and other crafts to heal their wounds and become stronger in body, culture and spirit. As stated succinctly by one of the teens: "It all teaches appropriate behaviors; how to relate in a good way."

Spirit

Across all five sites a spiritual renewal is occurring. This renewal appears to be taking place in three areas: in strict adherence to Christianity, in adaptation by traditional Christian practice to American Indian traditions, and in traditional American Indian spiritual revitalization. As has been true for American Indians for thousands of years, spirituality forms the basis of wellness.

As American Indian communities across the nation struggle to emerge from the past five centuries of cultural erosion and cope with trauma of epidemic proportion, spiritual revitalization becomes the foundation for their healing. At every site, the mental health systems of care rely on the spiritual realm as their primary source of strength and courage. Illness of any kind is viewed as an imbalance between the four quadrants of the medicine wheel, but it is here in the quadrant of spirit from which the answers spring and the road to wellness becomes clear.

Theme 1: Blending Christianity into American Indian Tradition

Throughout the recent centuries of spiritual and religious intolerance, there have been Christian religious leaders who have been successful in their efforts to convert American Indians to Christianity. Their success among Indian peoples was often dependent upon their willingness and ability to accommodate or adapt Christianity to fit the cultures of the communities they encountered. This accommodation continues today. The following beautifully describes an example of Christian and Indian blending:

St. Stephen's Catholic Church is located on the grounds of St. Stephen's School, one of the old boarding schools on the Wind River Reservation. With the support of a Catholic priest, the church has recently undergone a transformation.

The transformation began when the stained glass windows of the church were removed for cleaning. They were so old that they practically fell apart. A group of young Indian men decided to take a class in stained glass, so they could create replacement designs for the windows. After a brief class in basic stained glass work, they set about designing new windows for St. Stephens.

Each design they created is an Indian, specifically Arapaho, design. Elders were consulted to ensure that each symbol and color was used to reflect the correct meaning. Even though the young men were cautioned not to use circles in their design (because of the degree of difficulty and their novice experience level), circles are fundamental in meaning to many tribes, so they created art with circles anyway.

The professional art quality and the deep meaning of each piece as part of Arapaho legend and belief are astounding. The interior roof of the church looks like a star quilt, with bright multi-colors. The life-size crucifix of Christ on the altar is tied to tipi poles and has an eagle feather hanging from each of his hands and feet. The pulpit is a huge drum. Paintings of the Stations of the Cross have been replaced with fourteen American Indian drawings, depicting the Indian version of the twelve stations and adding two depictions which have deep meaning as part of the life cycle for the Arapaho people.

The church is a beautiful Indian sanctuary and full of American Indian influence. Funerals, weddings and prayer take place in this peaceful and profound setting on a daily basis.

It seems significant that:

- The church redesign was created by people who, after being told they did not have the skills to take on such a task, did so anyway and surpassed everyone's expectations.
- The church redesign was led by a group of young men, who quietly served as role models for others their age and younger children.
- The importance and great value of ensuring that all designs were correct in the story they told, as well as the colors used, was reinforced by the story telling and consultation of elders.
- The melding of Christianity and traditional American Indian beliefs used strengths from both, but emphasized American Indian in visual appearance.

Accommodation is not unique to the Wind River Reservation (home of the Northern Arapaho). On the Passamaquoddy Reservation, the Catholic church has made similar changes. The other three sites benefit from the blend of spiritual tradition with modern practices as well.

> *"Spirituality is unique to each individual. Within the community are traditional people and those who are not. The [*Kmihqitahasultipon Program*] is reflective of that and offers opportunity for tradition if people want it. The church told everyone what to do. The church did that, and now the community tells the church what to do. We have dream catchers in the church."*

> *"There are traditional healers at the health centers. There are sweat lodges where programs refer clients if clients express the interest in it, and sweat lodges at the health center and the ceremonial building and on Sugar Island at our cultural camp."*

Promising Practices

Honoring diversity within the group is a promising practice that the sites have had to develop out of necessity. These practices require acceptance of the great differences in spiritual orientation among members of the communities and even the same families. Encouraging participation in spiritual activities as an aspect of wellness is another promising practice.

Theme 2: Participants Articulate the Impact of Spiritual Renewal

You will see from the following quotations from parents, teens and project staff that mental health services, when resting upon a spiritual foundation, have the capacity to help people transcend their past. There was not one person we spoke to who did not embrace spirituality as part of the healing process.

The traditional Navajo four directions and SNBH (Sha a' naa whe bi ke' hozhoon) model is all-inclusive and holistic. K'e and family are intrinsic to the model, and family involvement should be intrinsic to services provided to children and families.

> *"Kids know. In some families they grow up with the language and sweat lodge. We offer socials, dancing for the community, teachings around the sweat lodge and talking circle. We want to be reflective of different parts of the community, whether kids want traditional or not. They are exposed to it, and they can make a decision to follow it. You can't divorce culture or spirit from this program."*
>
> *"One of my commitments was to this on a personal level. I allowed family members and my son to go with me to cultural events, and that fortifies the family. We set up the altar and go through the sweat together. If it were not for* Sacred Child, *we would not have gotten the opportunity to go through this experience as a family. They help pay for our transportation for these spiritual events.*
>
> *"One thing that moved the family toward healing was the Navajo tradition of ceremony. In the process of working with the family, the* K'e Project *provided some funds for ceremony. They were taught about the traditional uses of such things as smoke and herbs. We learned what their purpose is, how and when to use them...Ceremony heals up a child's mind. By going back to our way, it healed me, it healed my daughter."*[3]
>
> *"We now use smudging for cleansing of the spirit, talking circles and sweat lodge ceremonies; tobacco offerings are important aspects of our lives. We had a recent national evaluation, and everybody in the community brought food. We looked out the window, and four kids outside had formed a circle on their own using stones and were taking turns talking. One of them had not been able to take part in things a few years ago. The cultural part is so much a part of what we are doing at the health center. Someone could have smudged recently, and you come in and you say, "what smells so good?"*
>
> *"They took him [son] to the [sweat lodge]. He was at a point where he was thinking about his future and had dreams."*

Promising Practices

These project are using cultural restoration via mentors, groups, and activities to promote healing of Indian identity, foster development of positive cultural self-esteem, and give families the opportunity to tap into the strengths that can come from spiritual beliefs. The spiritual beliefs of almost all systems provide useful teachings that describe wellness. Further, the projects are using specific cultural approaches such as ceremonies and sweat lodges to facilitate families finding positive spiritual experiences. Other projects are providing stipends for children and their families to attend spiritual activities.

Theme 3: Spirituality

> *"Native dancing is spiritual. Basket making is spiritual. Drum making, drumming, it's all spiritual stuff; it all goes deep; it all means something. Not everyone can explain it, not everyone knows why, but it's just there."*
>
> *"My role is (to set a) lifestyle example. Certain people who live a certain life style their role is being there for the community. In receiving a pipe, my life is dedicated to the people. All people. In doing that, my life is a consistent learning, and my responsibility is to make sure that these teachings that I seek now from the elders, from the vision quest, from the ceremonies, from the people, I, in turn, have to bring it back to the community and share it. Spiritual leaders offer a lot of motivation to people to start learning. It is like a catalyst for them to find their own way."*
>
> *"The best spiritual leaders are those that direct the people's thinking, so their thinking allows them to come to terms with whatever they are looking for. We help them find it in a natural way."*
>
> *"Body, mind and spirit is the one person. That's the balance of who you are; what you do; it's always been an important part of my life. You have understanding in the head and feeling in the spirit."*
>
> *"Spiritual healers are listeners. When I am listening to someone talk about what has happened to him, I give all my attention to that person. I focus on nothing else. This way I can get into his world and learn what is going on there. Then I can take that information and help him find his way out of the pain and back to peace and harmony."*
>
> *"Spiritual people are not powerful in and of themselves. We are just tools the Creator uses. It is the Creator, not us, who heals people."*

Promising Practices

Sites emphasized the spiritual nature of crafts and social activities, which non-Indian people may misunderstand and view simply as social and/or creative activities. Integrating these activities into the projects' activities (e.g., basket making, native dancing, as well as ceremonies) is a promising practice. The integration of spiritual healers and elders into the entire care plan is a promising practice shared by all sites, although each child or family determines if this is appropriate for them. Collaboration with spiritual people may include ministers or other Christian persons, as well as traditional spiritual people. Each project uses methods that help families find resources that can invoke the positive effects of spiritual belief and tap into spirituality as a support.

Summary

> *"Spirituality is engrained in our language. For example, water has life and sustains people's life. Our word for water reflects that."*

Many parents felt that spiritualism permeates their lives. Many children and parents attribute their emotional and spiritual growth to their participation in the projects. They pointed to the projects' concern with their spiritual well-being as a key component to their healing. They were quick to emphasize that the elements of social relationships (context), mind, body, and spirit were inseparable.

For the five American Indian sites, spiritual elements were crucial. Many parents feel that spiritual elements in their lives are a necessary part of their healing and recovery. In many cases, families and staff reported that spirituality includes elements of both traditional American Indian and Christian religions. Similar to the dramatic redesign of the Catholic church interior to reflect Northern Arapaho heritage and beliefs (described previously), families in Maine say their church has been "taken over by the 12,000-year-old spirits of the Passamaquoddy people."

Many people are returning to traditional ways. A spiritual consultant to the *Sacred Child Project* reported that the "the best spiritual leaders are those that direct the people's thinking to allow them to come to terms with whatever they are looking for. We help them find it in a natural way." The project sites also emphasize that "spirituality is unique to each individual" and offer support for tribal spirituality, if families choose.

Each of these projects considers spiritual wellbeing to be an essential part of the balance that contributes to any individual's mental health. Spiritual wellbeing is promoted by teaching those behaviors and activities that help spiritual growth and by encouraging families to adopt those behaviors. The projects support reliance on a higher power and the development of a personal mission and vision. They emphasize the importance of interconnectedness and relationships. They help families examine alternative codes of conduct that are culturally known to help or hinder spiritual wellbeing. For example, when a youth learns about the drum as a cultural symbol, he or she also learns about the proper way to treat that item, its symbolic significance, its importance to the people and the obligation of the person in relationship to the drum.

Notes:

[1] Cross, T.L. (1995). Understanding Family Resiliency from a Relational World View. In H.L. McCubbin, E.A. Thompson, A.I. Thompson, & J.E. Fromer (Eds.). *Resiliencey in ethnic minority families. Vol. I: Native and immigrant American families.* Madison, WI: University of Wisconsin System.

[2] See *From Trout Creek to Gravy High, The Boarding School Experience at Wind River.* (1992-1993). Sponsored by the Shoshone Episcopal Mission's Warm Valley Historical Project, funded by the National Endowment for the Arts.

[3] McGregor, K. (1998, Fall). Culture matters. *Family Matters,* p.17.

Chapter VII–Implications

INTRODUCTION

The Children's Mental Health Service Program's emphasis on cultural competence has widened the door to the acceptance of cultural resources as important and viable. Discussion of the five American Indian sites demonstrates that building and sustaining culturally based services is a rich, complex, and challenging process. As such, the sites have developed promising practices for their communities that build on the cultural standards of their particular tribes or communities. These practices reflect an authentic community voice and demonstrate how individual wellness springs from community wellness.

Acknowledgement of the unique and often painful history of American Indian communities is important, both as a part of the reality of Indian existence and as an example of the great strengths and survivability of Indian people. It is important to note the challenges faced by the five sites as they developed an empowerment model of service within culturally strong, yet historically disenfranchised, communities. As the sites sought local support for their projects, they did so with an inherent understanding that many tribal communities were taught long ago "not to feel, but endure." In summary, although the principles of the system of care movement are a good philosophical fit with tribal sovereignty, many tribal communities have had little practical experience with programs that are truly inclusive in design and principle.

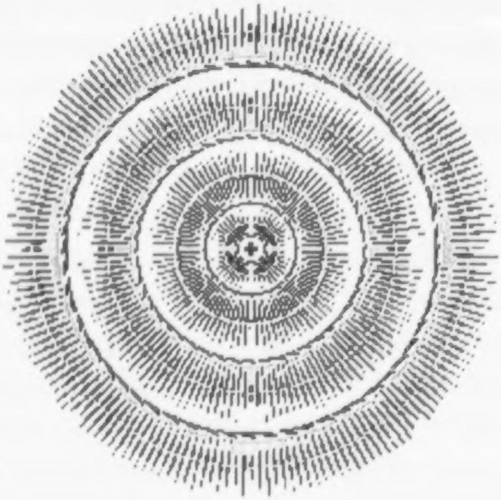
As American Indian families and community members continue to regain their role as stewards of the future of their children, the authors suggest that important considerations be reviewed as services are developed: American Indian cultural competence, staff considerations, development of partnerships, funding issues unique to tribes, and evaluation of outcomes.

American Indian Cultural Competence

A system of care must honor the diversity among tribes and be individualized to the cultural nuances within each tribal community. In addition, true cultural competence may look different at the organizational level, tribal or community level, and Indian family level. Competence is achieved if we can work with Indian children and families in a way that is not only responsive to their culture but makes the most of existing cultural and community resources.

Building programs based on the family voice and family involvement are welcomed in communities that historically had little experience with programs designed to be inclusive. As such, Indian family perspectives and cultural strengths must drive all programmatic decisions. Support, through action, of community ownership not only enhances cultural identity and cultural self-esteem, but also contributes to the revitalization of the traditional role and dignity of the Indian family.

Several of the tribal service sites began their initial work through a spiritual visioning process. This was a way to seek guidance on how to create and sustain healthy services and a healthy organization that could best serve their communities. The visioning of the projects is an example of organizational creation using the relational world viewpoint as discussed in Chapter 2. This visioning also demonstrates a belief that the origin, and the continuing life of the organization, must reflect the same sense of balance as in the medicine wheel.



The Indian service sites also demonstrate how traditional teachings that describe a state of wellness, balance, and harmony can be used as the vision and framework for program development. The sites took care to ensure that all aspects of their work, including service protocols and information systems, reflect the strengths and culture of their community.

In terms of clinical treatment, the service sites use an approach that is common across many tribes. Rather than viewing traditional healing as an adjunct to standard therapy, Indian sites show that their services are derived from, and revolve around, cultural values. Culture is the center, and mainstream services are the adjunct. Culture is not a support service; rather, when culture is the core from which all else is derived, tremendous opportunities become available. With the perspective of culture-as-center, every aspect of community life and culture offers healing opportunities. This view of culture, into which professional services are integrated, is found to be more effective in building responsive services for American Indian children and families.

Staff Considerations

The experiences of the American Indian service sites increased our awareness of important implications for both Indian and non-Indian staff. For example, as system of care change agents, all staff must be well schooled in the system of care philosophy to ensure that the philosophical hallmarks are reflected in all levels of planning and services. In addition, staff members frequently have an additional role as educators to co-workers in other settings who are not experienced in working within a system of care framework.

Staff may experience frustration, because the time required to build key cross-system relationships is rivaled by the time needed to address the direct service needs of Indian families. Staff also must find ways to open system doors that have traditionally been inaccessible or harmful to Indian families. Then, they not only must advocate for culturally responsive services for Indian families, but they also must reassure local Indian families that these adjunct services can be beneficial to their families' well-being. Mobilizing system change, while simultaneously providing services to families, can be a challenge for the American Indian service provider.

American Indian staff members bring unique strengths and challenges to the work, because they have chosen to serve in dual and simultaneous roles as community members and providers. American Indian direct service providers may be extremely knowledgeable of the obvious and obscure needs of Indian families. Both their knowledge of the community and their role as a community link to the project resources are invaluable. However, Indian service providers may well be helping a family whose life mirrors that of their own relatives. Their ability to help others, while maintaining their personal and professional lives, may depend on where they are in their own journey of dealing with community and family trauma. Within the organization, thoughtful and respectful mechanisms to support the American Indian service provider on multiple levels (organizational, supervisory, and peer) could contribute to the long-term balance and sustainability of staff and services.

Non-Indian staff members are also in a unique situation. Non-Indian staff may have their first experience as a "minority" when they work in a cultural context that may be outside of their life experience. Non-Indian success in an Indian work and service environment requires that they value the knowledge of their American Indian colleagues, maintain attitudes of flexibility, and demonstrate a willingness to let local cultural strengths drive decision making processes. From a communication perspective, many non-Indian staff members have to adjust to a community of storytellers.

Implementing a staff training and development plan in which staff members have an active role in the planning serves several purposes. First, the job burnout potential and the struggle with boundary issues in a community-serving-community environment is high. An effective staff development plan should address licensing and accreditation needs, but also it should look beyond credentials and support the values, attitudes, and coping abilities necessary for the delicate job of providing mental health services to tribal communities. Second, effective training and education does not negate the value of life experience, but rather provides support to enrich life experience and increase the provider's ability to help. Last, attention to staff development increases the sorely needed pool of Indian and culturally competent non-Indian mental health professionals.

Development of Partnerships

The expansion of effective partnerships, both within existing tribal resources and with external mainstream resources, is a necessary part of building new systems of care. Understanding the cultural and historical context of both tribal services and mainstream provider communication would be helpful in developing partnership-building strategies. Issues of distrust, miscommunication, and institutional racism are long standing barriers that must be addressed before effective partnerships can be developed. In addition, different perspectives of organizational culture also may contribute to the challenge of partnership-building.

For example, challenges exist within tribal services. The new thinking of system of care as community-inclusive and driven by community values may be contrary to the organizational culture of Indian bureaucratic institutions. Some tribal services may be narrowly focused on categorical funding and services, which may be contrary to the broader scope of system of care work. Or, tribal family relationships or public airing of service complaints may color a view of a particular tribal service.

Mainstream partners must assess their attitudes about the viability and credibility of American Indian projects that are rooted in culture. American Indian programs should be viewed as viable and credible programs rather than mere experiments or expendable add-ons. Traditional practices have only recently received professional respect and early financial support from the mainstream mental health system.

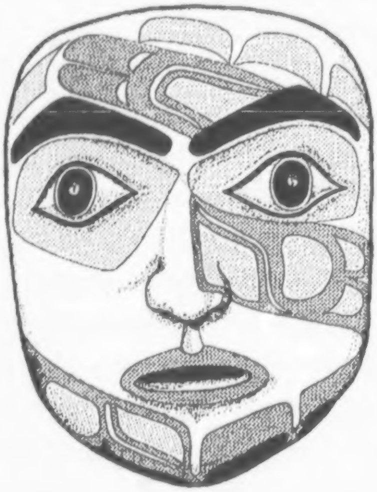
For the benefit of American Indian children, strategies must be implemented to increase cross-system partners in all life areas pertinent to the wellness of children and communities. The element of shared risk among providers implies that, in partnership-building, attention must be paid to the new definition of roles and responsibilities among cross-system providers. Historic distrust may imply that discussion of a process for dispute resolution should be an open part of partnership building. In addition, American Indian providers must determine ways to market their approach as not only culturally competent, but as cost-effective services with reliable positive outcomes.

Funding Considerations

For many tribal sites, advancing the concept of cultural sustainability has been far easier than securing financial sustainability. Several factors have contributed to funding considerations unique to American Indian communities. These include the ability to compete for diverse funding streams with strong information systems, data, and fiscal infrastructures in place; the unique aspects and funding barriers of a nation-to-nation status; and culturally based promising practices that fall outside of conventional funding streams.

Tribal communities have struggled for decades to build strong organizational and financial infrastructures, frequently building sophisticated systems with inadequate resources. In instances like this, the direct service capacity may be temporarily diminished as the internal resources get redirected to help build infrastructure. As the movement toward managed behavioral health care grows, the need for strong infrastructure becomes even more important.

Medicaid managed care offers a good example of the challenges faced by tribes that hold nation-to-nation status. The overlay of managed care on Medicaid programs, which already vary from state to state in terms of eligibility, services covered, and administration of programs, add even more challenges with regard to support for American Indian families. There are currently no national standards for provisions in state Medicaid programs that would provide equal protections for American Indians and Alaska Natives.



Funding and compensation for cultural services presents a unique dilemma. In some cases, the intervention practices are so completely integrated with the culture that it is difficult to articulate what is culture and what is the program service. The negotiation of appropriate billing categories that support culturally based services is critical to the sustainability of traditional and culturally competent services. In addition, other questions need to be addressed at the tribal level and resolved within each community's standards of cultural acceptability. For example, does compensation damage the integrity of ancient cultural practices? Can traditional healers be compensated in a way that does not violate their spiritual beliefs?

American Indian providers must determine ways to diversify their funding streams, support traditional approaches as viable and billable, and market their approach as not only culturally competent, but also as cost-effective services with reliable positive outcomes.

Outcome Evaluation

In today's world, the field of outcome evaluation has taken on enormous importance, and tribal programs are well aware of the power and potential uses of evaluation tools. Unfortunately, due to historical misrepresentation of "behavioral studies of native communities," Indian community leadership tends to cast a wary eye toward the concept of evaluation. As discussed in the partnership section of this chapter, communication and trust building between American Indian providers and the field of evaluation needs to be revisited, and strong partnerships need to be forged. Five areas in the outcome arena have implications for supporting and documenting the healing and wellness of Indian children and families: impact of cultural, partnerships with and among evaluators, program improvement uses, feedback loops to the community, and the ability to impact continued system improvements.

Cultural Responsiveness

The foundation of the promising practices described in this monograph discusses the use of culture as medicine for community wellness. As such, previous chapters illustrate a myriad of ways that culture is used to effect positive change in Indian children and families. The use of culture contrasts with Western evaluation measures, whose standards were not set for an American Indian population. In addition, Western evaluation tools have both known and unknown biases within the instruments. The challenge for both evaluators and tribal providers is to determine ways to measure the impact of culture on behavior. For example, how would one measure the impact of tribal ceremony on a child's behavior? In the forum of storytelling, how can one measure the impact of the metaphor or the relationship a child may have with the storytelling moment or with the storyteller?

We also need to determine if American Indian outcome indicators for Indian children are the same as standardized child behavior check lists. Many indicators would be shared for both Indian and non-Indian children, but tribal communities may have other indicators that are equally, or more, important than, for example, "improved school attendance." A tribal community may be more interested in determining whether an Indian child is participating, at an age-specific level, in cultural practices of the tribe, because this is fundamental to carrying tribal traditions forward into future generations.

Partnerships with Evaluators

Central to meaningful outcome data is the relationship and partnership between American Indian sites and the evaluators. Equally important is the relationship and partnership among evaluators who include American Indian populations in their target areas. As discussed in the earlier Partnership section of this chapter, relationship building among those involved in evaluation is critical to the quality of communication and the commitment to constructive problem solving. Evaluators in the field should share their rich experience and knowledge of American Indian sensitivities and successful integration of culturally based measures.

Summary

American Indian communities have the human resources, the talent, and the commitment to return balance to their communities. The American Indian service sites, from the small and self-contained Passamaquoddy Nation in Maine to the Navajo Nation, the largest in the United States, have used culture as the foundation of their work on behalf of Indian families. Their "culture as strength" approach has resulted in life changing services to Indian families who have children with emotional and behavioral disorders.

The value of restoring the dignity of Indian families and the complexity of the development of new systems of care within American Indian communities should not be underestimated. In all cases, the blending of old and new, Indian and mainstream, traditional and innovative, have resulted in both success and challenges for long-term sustainability.

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Appendix A–Parent Questions

What we are looking for is BALANCE, a sense that all things interact and that when they are in harmony, things work the best. The four areas of a person's life that need to be in harmony are the CONTEXT, BODY, MIND, and SPIRITUAL areas.

CONTEXT–refers to family, community, culture, work and play - the social areas of life in which you interact with other people.

Questions:

1. Has this program made use of extended family and other relatives to help your family take care and help the children?
2. Are there non-relatives in your community who have been helpful to you through this program?
3. Has this program made a difference in the ways that you help your child or children? Do you now ask people to help who you did not think of asking before? Have they been helpful? How?

BODY–refers to not only physical health, but how we sustain ourselves physically including eating, medical care, and healthy family relationships. This includes meeting medical, nutritional, and recreational needs.

Questions:

1. Have you or your child (children) participated in any cultural activities to improve physical health? Examples could include:
    - Special tribal celebrations with food served to mark the occasion
    - Herbal or plant remedies for certain illnesses
    - Smudging or other ways of cleansing for special occasions
    - Tribally-based recreational opportunities such as dancing, playing games
2. How has this affected your child's health and mental health?
3. What other remedies for health problems has the program helped you to use for your child (children)? Examples could include:
    - Medical clinics
    - Mental health clinics
    - Medication
    - Participation in recreational activities
4. How has this affected your child's health and mental health?

MIND–refers to the mind and the emotions, supported by intellectual pursuits such as storytelling, instilling morals and values, talk about how others have managed to get by, and the emotional support of an approving look or a pat on the back from community members.

Questions:

1. Have you and/or your child (children) participated in storytelling or other discussions or activities that helped you and your child to develop a positive self-image? Can you give some examples?
2. Have you learned Indian ways to deal with your child and his or her problems that you were not aware of before you participated in the program? What are they?
3. Can you think of some specific cultural practices that you and/or your child have been involved in that have helped you (Example: basket making, participation in Pow Wows, drumming)?

SPIRITUAL–includes both positive and negative practices learned from faith, prayer, meditation, healing ceremonies, spiritual leaders or teachers. NOTE: the role of the Christian churches is important in this area as well.

Questions:

1. Have you or your children been exposed to spiritual teachings to help restore a sense of peace and harmony to your world (examples: Bible stories, moral tales)?
2. Has the program helped you to find and talk to spiritual people (example: priest, minister, Indian spiritual leaders) who could help you spiritually?
3. Have you or your family participated in any rituals or ceremonies to help restore balance to your lives, either through the purging of negative forces or the development of positive forces? Do you use any Indian traditional remedies to restore balance in the spiritual area (example: sweat lodge)?
4. Has the program helped your family develop a vision for the future through the development of positive thinking or ways to improve family functioning (Example: involvement in AA)?
5. If this program were not here, what would you do? What ways of helping has this program given you that you would not have had if this program did not exist?

Appendix B–Provider Questions

What we are looking for is BALANCE, a sense that all things interact and that when they are in harmony, things work the best. The four areas of a person's life that need to be in harmony are the CONTEXT, BODY, MIND, AND SPIRITUAL areas.

CONTEXT–refers to family, community, culture, work and play - the social areas of life in which you interact with other people.

Questions:

1. Can you think of ways your program uses extended family and relatives to help families take care of their children?
2. Are there places in your community where kids or families can go for help when they need it?
3. How is being a member of this community different (better) than being part of the surrounding communities?
4. We have learned, based on centuries of oppression, to have a sixth sense about where we are welcome and where we are not. This has become an important survival skill for Indian people. Is information about our history and our relations with the surrounding community shared with children and families (in a positive way) so that they will understand the larger social context?
5. Can you share examples of cultural components of your program that are working well? Examples could include:
   - A system in which everyone contributes in some way without expecting anything in return
   - Support and help cycle through the community as they are needed
   - Everyone looks out for all of the children

BODY–refers to not only physical health, but how we sustain ourselves physically including eating, medical care, and healthy family relationships.

Questions:

1. Does the program have medical or nutritional components to increase the health of children and families?
2. What is your relationship to the medical clinic? Is this a helpful, collaborative relationship?
3. Do any of the children or parents take medications? Are these helpful?
4. Do any of the children or parents use herbal or food-related medicines for healing or for ensuring wellness? Examples could include:
   - Special tribal celebrations with food served to mark the occasion
   - Herbal or plant remedies for certain illnesses
   - Smudging or other ways of cleansing for special occasions

MIND–refers to the mind and the emotions, supported by intellectual pursuits such as story telling, instilling morals and values, talk about how others have managed to get by, and the emotional support of an approving look or a pat on the back from community members.

Questions:

1. Does the program use story telling or other ways of self-talk to teach children coping skills and values?
2. Are there specific, tribally unique cultural practices (for example, basket making?) that are used with families and children to increase their senses of identity, values, and life skills?
6. How does the program help children develop a positive attitude toward being Indian (example: participation in Pow Wows, drumming)?

SPIRITUAL–includes both positive and negative practices learned from faith, prayer, meditation, healing ceremonies, spiritual leaders or teachers. NOTE: the role of the Christian churches is important in this area as well.

Questions:

1. Does the program use spiritual teachings to help children and families (examples: Bible stories, moral tales)?
2. How does the program help facilitate access to spiritual people (example: priest, minister, regular church attendance, Indian spiritual leaders and ceremonies)?
3. Does the program use any rituals or ceremonies to help families and children restore balance to their lives, either through the purging of negative forces or the development of positive forces?
4. Does the program help families develop a vision for the future for them as a family, through the development of positive thinking or plans to improve their ability to work together as a family (example: involvement in AA)?
5. Do you use any Indian traditional remedies to restore balance in the spiritual area (example: sweat lodge)?

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EFF-089 (5/2002)